DOCUMENT RESUME

ED 426 771 PS 027 215

AUTHOR	Lipsitt, Lewis P., Ed.
TITLE	The Brown University Child and Adolescent Behavior Letter, 1998.
INSTITUTION	Manisses Communications Group, Inc., Providence, RI.
ISSN	ISSN-0898-2562
PUB DATE	1998-00-00
NOTE	134p.; For 1996 issues, see ED 407 163. For 1997 issues, see ED 418 786.
AVAILABLE FROM	Manisses Communications Group, Inc., 208 Governor Street, Providence, RI 02906; phone: 800-333-7771; fax: 401-861-6370; e-mail: lwjackim@manisses.com (institutions, $177 per year; individuals, $117).
PUB TYPE	Collected Works - Serials (022)
JOURNAL CIT	Brown University Child and Adolescent Behavior Letter; v14 n1-12 Jan-Dec 1998
EDRS PRICE	EDRS Price MF01 Plus Postage. PC Not Available from EDRS.
DESCRIPTORS	Adolescent Development; Adolescents; Adoption; Behavior Problems; Child Abuse; *Child Behavior; Child Development; *Child Health; Child Psychology; *Childhood Needs; Children; Early Intervention; Educational Testing; Emotional Disturbances; Inclusive Schools; Infants; Learning Disabilities; Newsletters; Obesity; Parent Participation; Parenting Skills; Prenatal Drug Exposure; Prevention; Resilience (Personality); Self Esteem; Substance Abuse; Suicide; Violence; *Youth Problems
IDENTIFIERS	*Adolescent Behavior; Sleep Position

ABSTRACT

These 12 monthly issues from 1998 explore problems encountered by children and adolescents. Regular features include "Keep Your Eye On...," brief accounts of research into childhood and adolescent problems, "What's New in Research," summarizing research from recent publications and professional conferences; "Commentary," editorials from professionals working with children and adolescents; "Announcements," events and conferences of interest; book reviews; and client handouts for use by practitioners. Major topics include: (1) infant sleep position and malformations, and juvenile sex offender programs (January); (2) learning disabilities and inclusion (February); (3) parent involvement, suicide, psychosocial problems and hunger, and cigarette promotional items and smoking (March); (4) the Adoption and Safe Families Act, the shame response, and childhood depression and anxiety (April); (5) school violence, early intervention, and childhood obesity (May); (6) self-esteem and resilience, children of parents with psychological disorders, and bedwetting treatment (June); (7) early stimulation and brain development, and self-mutilation (July); (8) child abuse prevention programs and documentation (August); (9) school testing, campus drinking, and language-based disabilities mistaken for ADHD (September); (10) problems with the time-out method, eating disorders treatment, and childhood abuse as risk factor for adolescent psychiatric disorder (October); (11) social factors and substance abuse prevention, new treatments for children's weight problems, and incidence of adolescent dangerous behavior (November); and (12) adolescent suicide, nurturing

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children's feelings of gratitude, and prenatal cocaine exposure (December). A year-end index facilitates searching for particular topics. (KB)

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ISSN 0898-2562

The Brown University Child and Adolescent Behavior Letter

Providing the link between behavioral research and your clinical work.

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New Programs

Juvenile sex offender program reduces recidivism

By Wallace A. Kennedy, Ph.D., and Marie P. Hume, Ph.D.

Aftercare surveillance of the 114 released, treated sex offenders who graduated from a Florida treatment program shows a 96 percent success rate in reducing recidivism.

The 12-month Specialized Treatment Program was developed eight years ago at Florida State University and at the Arthur G. Dozier School, a deep-end treatment facility for male juvenile delinquents that is part of the Juvenile Justice Department of the State of Florida. The program uses relatively standard group treatment along with an educational program and individual therapy.

Turning around the cold and callous indifference of the perpetrator is the backbone of treatment.

The importance of such a program cannot be overestimated. Criminal acts of children on children have reached epidemic proportions over the last decade. The increase in sexual offenses by adolescent males is astounding; 973 last year in Florida alone. Even more disconcerting is the fact that most adult pedophiles, who molest hundreds of victims during their lifetimes as predators, are male and almost all started as juvenile sex offenders.

In Florida, adjudicated sex offenders who have failed at less-restrictive settings are sent to the Dozier School. This group does not include rapists of older children or adults; rather, most of the offenders' crimes were those of opportunity committed

(turn to 5)

Vol. 14, No. 1 January 1998

Inside This Issue

States with safe-storage laws for firearms prevent unintentional shooting deaths among children. *See page 3*

It's less stressful to be a procrastinator, but only in the short-term. *See page 3*

Fluoxetine is better than placebo for childhood depression, according to new research. *See page 3*

Guest Commentary: Robert J. Sternberg, Ph.D., says we're looking for smarts in all the wrong places. *See page 7*

This month's client handout **You can help your adolescent in the search for identity.**

Putting babies to sleep on their backs causes malformations

By Jacqueline Mast, M.S.Ed.,P.T. and Lucie Beirne, Asst.

Placing babies on their backs to sleep as a way of lowering the incidence of Sudden Infant Death Syndrome (SIDS) has had two unfortunate, unanticipated results:

1. Infants are no longer routinely placed in prone positions (on their stomachs) to play. Because of this, they do not readily develop the arm or neck extensor strength to lift their heads more than fleetingly. Their muscles of extension are quickly exhausted because they are affected by lack of use.

   Infants currently spend most of their time in a supine position (on their backs). Infant carriers, car seats and infant swings all require a semi-recline supine/sit posture. Compared with the skills of the infant of 10 years ago, developmental skills in the motor arena have changed considerably in the early weeks of life. Whereas infants who spent time in prone positions developed strength first in *extensor muscles* — those used to straighten a limb — *flexor strength* — the muscles used to extend joints — now predominate in early infancy.
2. The incidence of infants pre-

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The Brown University Child and Adolescent Behavior Letter

Editor: Lewis P. Lipsitt, Ph.D.
Professor Emeritus of Psychology, Medical Science, and Human Development at Brown University

Contributing Editors:

Stephen L. Buka, Sc.D., Assistant Professor, Department of Maternal and Child Health, Harvard University School of Public Health

Cynthia Garcia Coll, Ph.D., Professor, Education, Psychology and Pediatrics, Chair of Education Department, Brown University

Ferdinand Jones, Ph.D., Professor of Psychology, Brown University; formerly director of Brown University Student Counseling

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Carol Lewis, M.D., Clinical Instructor in Pediatrics, Brown University School of Medicine; private practice

Theodore R. Sizer, Ph.D., University Professor Emeritus, Brown University; Chairman, Coalition of Essential Schools; former director, Annenberg Institute for School Reform

Sally Zierler, D.P.H., Associate Professor of Medical Science, Brown University School of Medicine

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Resources

Report explores facets of violence

The latest special report from the American Psychological Society's Human Capital Initiative series is now available. Entitled *Reducing Violence: A Research Agenda*, the special issue of the *Observer* addresses violence as a health problem in need of further attention and research.

The causes, treatment and prevention of violence all need to be considered in present and future studies, according to the report. In particular, integrating findings of criminological, sociological, psychological and neurological disciplines will go a long way toward promoting understanding of violence as a public-health concern.

Copies of the report are available from the American Psychological Society, 1010 Vermont Ave. NW, Suite 1100, Washington, DC 20005-4907; phone (202) 783-2077; fax (202) 783-2083; e-mail APS@CAPCON.NET.

Respond to sexual harassment assertively

Stopping sexual harassment starts with taking action. ACORN, an organization that assists employees and their families with harassment issues, suggests that victims or witnesses of sexual harassment respond promptly and appropriately to aggressors.

They suggest victims:

- Respond by making their feelings known.
- Record the specifics of the incident, including the time, place, and others who may have witnessed the behavior.
- Report harassment according to company policy.
- Talk to others in the work area.
- Write a letter to the harasser if face-to-face confrontation was unsuccessful.

For help in regard to harassment, call ACORN DIRECT at (800) 865-3200.

Keep Your Eye On

... video surveillance.

Covert video surveillance can be an effective means of saving children from severe child abuse deaths, according to a recent study published in the November issue of *Pediatrics*.

David P. Southall, M.D., and colleagues observed 39 children of parents who were suspected of inducing illness in their children. Most of the children were suspected of being victims of "apparent life-threatening events." The children, ages two to four years, were admitted to the hospitals and observed by staff with hidden video cameras.

After reviewing the videos, researchers determined that child abuse was evident in 33 of the cases. Intentional suffocation was the form of child abuse in 30 of the cases. The children observed in this study had 40 siblings, 12 of whom died unexpectedly. Eleven of those deaths had been classified as Sudden Infant Death Syndrome, but after video observation of their siblings, four of the parents admitted to suffocating eight of the children.

What's New in Research

How effective are state gun safe-storage laws?

State safe-storage laws for firearms appear to prevent unintentional shooting deaths among children, according to Seattle researchers. An ecological study of firearm mortality from 1979 to 1994 in all 50 states among all children younger than age 15 evaluated unintentional deaths, suicides and homicides due to firearms. The study also took into account 12 states with laws passed between 1990 and 1994 that made gun owners responsible for storing firearms in a manner that made them inaccessible to children.

Among children under age 15, unintentional shooting deaths declined by 23 percent in states with gun safe-storage laws. Gun-related homicide and suicide showed only modest declines, according to the researchers, but that decrease raises at least the possibility that safe-storage laws might have some impact on those two outcomes.

"State safe-storage laws intended to make firearms less accessible to children appear to prevent unintentional shooting deaths among children younger than 15 years," the authors conclude.

"State gun safe-storage laws and child mortality due to firearms," P. Cummings, D.C. Grossman, F.P. Rivara, et al., *Journal of the American Medical Association* 28:1084-1086, 1997. For reprints, contact Dr. Peter Cummings, Harborview Injury Prevention and Research Center, Box 359960, 325 Ninth Ave., Seattle, WA 98104-2499.

What are the effects of procrastination?

Is procrastination harmful or beneficial? Apparently, it's less stressful to be a procrastinator, but only in the short-term, according to two longitudinal studies of college students. In the first study, students were given due dates for term papers in a health psychology course as well as a schedule for two upcoming exams. However, students were told that if they could not meet the term paper deadline, they could have an automatic extension to a later date.

Participants were given the General Procrastination Scale and completed daily symptom checklists and weekly measures of stress and work requirements. Procrastinators turned in their papers significantly later than non-procrastinators and received significantly lower grades than non-procrastinators, both on the term paper and the two exams. Procrastination scores were correlated with stress and symptom reporting as well. Although procrastinators had significantly less stress and fewer symptoms than non-procrastinators did, procrastinators reported significantly more relief after turning in their papers than did non-procrastinators.

The second study was similar to the first, except that students also filled out reports of any visits to health care professionals during the health psychology class. In that study, procrastinators reported more health symptoms, stress and visits to health care professionals than did non-procrastinators. Results from both studies indicate mixed evidence regarding the disadvantages and benefits of procrastination, although the self-defeating behavior pattern of procrastinators led to short-term benefits — and long-term costs.

"Procrastinators end up suffering more and performing worse than other people," the authors conclude.

"Longitudinal study of procrastination, performance, stress, and health: The costs and benefits of dawdling," D.M. Tice, R.F. Baumeister, *Psychological Science* 8(6):454-458, 1997. For reprints, contact Dr. Dianne M. Tice, Department of Psychology, Case Western Reserve University, 10900 Euclid Ave., Cleveland, OH 44106-7123.

Prozac effective for depressed children

In a landmark study, fluoxetine (Prozac) was found to be better than placebo among children and adolescents in the acute phase of major depressive disorder (MDD). The study is the first to demonstrate this antidpressant to be more effective than placebo in a large study of children and adolescents. Among 96 children and adolescent outpatients ranging in age from 7 to 17 years old with nonpsychotic MDD, 48 received 20 mg of fluoxetine and 48 received placebo for eight consecutive weeks. Participants received three evaluation visits that included structured diagnostic interviews. Every patient also received some

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type of psychotherapy.

Fifty-six percent of patients on fluoxetine and 33 percent on placebo were rated much or very much improved on the Clinical Global Impressions scale at study exit. There were also significant differences in weekly ratings of the Children's Depression Rating Scale — Revised after five weeks of treatment. Response rates were equivalent for children ages 12 and younger and those ages 13 and older. Complete symptom remission occurred in 31 percent of fluoxetine patients and 23 percent of placebo patients.

"A double-blind, randomized, placebo-controlled trial of fluoxetine in children and adolescents with depression," G.J. Emslie, J. Rush, W.A. Weinberg, et al., *Archives of General Psychiatry* 54:1031-1037. For reprints, contact Dr. Graham J. Emslie, Professor of Psychiatry, The University of Texas Southwestern Medical Center at Dallas, 5323 Harry Hines Blvd., Dallas, TX 75235.

Recommended Reading

ADOLESCENT DYSFUNCTIONAL BEHAVIOR: CAUSES, INTERVENTIONS, AND PREVENTION — *Gary M. Blau & Thomas P. Gullotta (Eds.), Sage Publications, Thousand Oaks, Calif., 304 pages, $24.95 (paperback); (805) 499-9774.*

This volume seeks to answer questions such as: How do adolescents' behavior problems develop? Why are teen crime and suicide on the rise? Are there reliable ways to prevent or treat these problems? Among the topics covered are teen defiance and hostility, criminal misconduct, substance abuse, depression, eating disorders and suicide.

Malformations

from page 1

senting with *deformational plagiocephaly* has increased. Deformational plagiocephaly is characterized by a dramatic "flat spot" on and resultant asymmetry of an infant's skull. This spot is caused by continual pressure being placed on that area. This pressure is usually due to the position of the child while lying down.

In order to get a good idea of exactly what deformational plagiocephaly means, one must follow the growth of an infant beginning before he or she is born. At nine weeks of gestation, the frontal and occipital bones are formed. At 12 weeks, the parietal bone begins to form. These three bones make up the skull.

In the case of a baby with deformational plagiocephaly, there is pressure in the uterus against one of the developing cranial bones. This pressure may be caused by either an asymmetrical position of the infant in utero or premature descent into the mother's pelvis. Because of this continuing pressure, a flattened section of the skull forms. To combat increasing intercranial pressure, the opposite site of the head bulges.

During the neonatal period, the infant becomes accustomed to the feeling of pressure on the flat portion of the cranial bone, and strives to maintain this pressure. As a result, he or she creates a position of comfort, generally one with the neck turned to one side with the head tilted in the opposite direction.

The child continues to place pressure on the flat bone by sleeping and, as often as possible, resting his or her head on the flatter side. This allows the flat cranial bone to become flatter still, while increasing the bulge of the opposite cranial bone.

Flattening of facial features

The most prominent feature of a patient with plagiocephaly is the asymmetry of the skull. However, this bony imbalance can also result in distortion or flattening of facial features. One cheekbone may be lower than the other. One ear may be further back on the head; one eyelid opening may appear smaller. Generally, one cheek will be considerably larger than the other.

Since the child puts pressure on the flat area of his or her head, often the neck muscles on the opposite side are stretched out, and the muscles on the corresponding side are short and tight. This condition, torticollis, is found in many children with plagiocephaly. Parents may notice the infant's tendency to turn his or her head in one direction only.

The diagnosis most commonly associated with plagiocephaly is torticollis. Two-thirds of all patients with plagiocephaly have this condition. Torticollis occurs when an infant's head has been situated in such a way that it is sloped with the head rotated to one side, and tilted to the other.

Because of the positioning in utero, hip dysplasia and/or positional club foot are other conditions sometimes associated with deformational plagiocephaly.

Reversing the effects

Several methods are used to help reverse the effects of this disorder. The goal of physical therapy is the elimination of the position of comfort. The physical therapist must develop stretching and strengthening exercises and positioning that counteract the po-

You can help your adolescent in the search for identity

Their bodies kick into overdrive. They find themselves disoriented, scared and alone. They become moody, secretive and sarcastic. You don't recognize your own child. What happened to the child you used to know? The answer: adolescence.

In the teenage years, young people begin their quest for identity. To help you understand your child's adolescence, Les Parrott, Ph.D., a professor of psychology, offers the five most common ways in which teens demonstrate their struggles with identity.

You can help adolescents discover the most stable aspects of their identities by becoming aware of what they are going through.

Through status symbols. Adolescents try to establish themselves through prestige — wearing the right clothes, having the right possessions, from stereos to sunglasses. These symbols help form teen identities by expressing affiliation with specific groups.

Through forbidden behaviors. Teens often feel that appearing mature will bring recognition and acceptance. They begin engaging in practices they associate with adulthood — tabooed pleasures — such as smoking, drinking, drugs and sexual activity.

Through rebellion. Rebellion demonstrates separation. Teens can show that they differentiate themselves from parents and authority figures, while maintaining the acceptance of their peers.

Through idols. Celebrities may become "models" for teens who are looking for a way of experimenting with different roles. They may identify with a known figure, trying to become like that person, and in effect, losing hold of their own identity. This identification with a well-known personality gives teens a sense of belonging.

Through cliquish exclusion. Teens often can be intolerant in their exclusion of their peers. Since they are constantly trying to define and redefine themselves in relation to others, they do not want to be associated with anyone having unacceptable or unattractive characteristics. They try to strengthen their own identities by excluding those who are not like themselves.

Offering help

Establishing an identity is not an easy process. There are difficult and confusing choices at every step of the way. You can help adolescents discover the most stable aspects of their identities by becoming aware of what they are going through, the ways in which they attempt to mold their identities and by being patient. Try these exercises with your adolescent as a way to open up discussion about identity-building and values.

- Draw a set of three concentric circles. Then have your teen list or describe the personal characteristics that are most important and resistant to change in the innermost circle; the aspects least important and least stable in the outermost circle; and the aspects of intermediate importance in the middle circle. Use this chart to talk about values and the threat that peer pressure poses to unpopular beliefs.
- Using some old magazines, have your adolescent create two collages: one entitled "Who I Am," and the other, "Who I Would Like to Be." After the collages are completed, discuss why the specific images were chosen in each collage. Ask how the collages compare to each other and how the images portrayed in each collage show satisfaction or confusion about identity.
- At the top of a sheet of paper, write the words, "Who Am I?" Then have your teen write down 20 responses to this question as quickly as possible, without self-censoring. Discuss the answers, as well as the process of choosing each answer.

The Brown University Child and Adolescent Behavior Letter

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sition of comfort. In the early weeks, stretching can be accomplished when the child is relaxed in the arms of an adult. As optical and labyrinthine righting reflexes develop, strengthening can be accomplished by eliciting those reflexes that move the infant's head away from the position of comfort.

In severe cases of plagiocephaly, where exercise and positioning have not resolved the head shape by age six months, a child can be helmeted. This helmet, fabricated by an orthotist, puts pressure on the bulging areas of the cranium, while allowing the flat sections of the skull to grow into a normal shape.

Helmets are fashioned out of a cast of the infant's head. The orthotist pads the interior of the helmet appropriately. A helmet is generally worn for four months, during which time the orthotist will make adjustments according to the growth and changes of the skull. The helmet should be worn all the time and should, along with therapeutic intervention, completely eliminate the position of comfort.

The ideal age for a baby to be helmeted is approximately six months, as the cranial sutures are still soft enough to be molded and the sleep positions can be changed with reduced threat of SIDS.

Those infants who are not treated may suffer from permanent distortion of the skull and face. This, in turn, can lead to increased facial asymmetry and resulting visual impairment. Furthermore, in many cases, the child neglects the occipital side of the body. Hand use on that side is diminished and less mature than the hand on the side toward which the child faces.

Complete recovery is possible

If diagnosed early enough, most infants recover completely from deformational plagiocephaly. However, the problem is that plagiocephaly is as yet a relatively unheard-of disorder.

Parents may not be able to identify plagiocephaly as they might an obvious ailment such as a fever or a respiratory problem. Some parents will notice facial and cranial abnormalities, but will not seek help immediately. This can prove to be extremely dangerous, for when dealing with plagiocephaly, time is of the essence, as head shape is rather fixed once the cranial sutures close.

Physical therapists must understand what steps to take in order to reverse plagiocephaly's effects as well as how to help the parents to work with them. It is necessary to acquaint pediatricians with the symptoms of this relatively easily corrected condition. Furthermore, physicians must acknowledge physical therapy's vital role in treatment. ■

Jacqueline Mast is president of Mast Clinic, and Lucie Beirne is research assistant at the clinic. Mast Clinic is a Portland, Maine-based developmental evaluation and physical therapy program for infants and young children. For more information, call the clinic at (207) 854-2733.

Sex offenders
from page 1

against known victims (siblings, neighbors or schoolmates). Those male juveniles committed to this relatively standard, high-security juvenile facility for whom the yearlong sex offender program is appropriate are identified through the initial, traditional, but intensive diagnostic prescreening conducted on all adjudicated students on campus. (See box, page 6)

Thawing the offenders' cold indifference

After being admitted to the program, students are prepared for the minimum compliance required for successful treatment through a three-month orientation. Students in total denial and fully uncooperative are put on a waiting list and are treated in individual therapy until they realize that the sentencing judge will expect them to successfully complete sex-offender treatment before allowing them to return to the community.

Success in sexual-offender treatment requires significant progress in five specific areas: admitting to the crime, insight, empathy, support and responsibility. The student must publicly, in the group, admit that his previous sexual-offending behavior is wrong and harmful to the victim and to the student himself. He must understand and acknowledge the erroneous belief system that permitted the irrational thinking, feeling and behaving that allowed him to commit the offense, which resulted in his incarceration and treatment. He must comprehend and articulate a level of empathy for his victim(s) and recognize the damage he has caused him, her or them.

Achieving this step, identification with the victim, is the most difficult part of the treatment program and requires the most skill from its leaders. Turning around the cold and callous indifference of the perpetrator is the backbone of treatment.

As a way of atonement, the stu-

dent is expected not only to assume responsibility for his own acts, but through group participation, to help others to gain empathy for their victims.

A significant characteristic common to nearly all untreated sexual offenders is their attitude that the offense was not their fault. Successful treatment, then, involves their learning to be good citizens: Sex offenders have other undersocialized problems that need to be dealt with as their attitude toward sexual responsibility is fixed.

How the program is structured

After the three-month orientation and screening period, students attend 24 weekly group meetings, each about one hour in length. Two sessions are devoted to each of these 12 topical areas:

- Account of sex-offender histories and immediate offense.
- Patterns of thinking and fantasy preceding offense.
- Identification of feelings and their relationship to behavior.
- Sexual abuse cycle.
- Why the offense occurred.
- Relapse prevention plan.
- Sex roles.
- Erroneous belief system analysis.
- Anger management.
- Communication and social skills.
- Traumatic events, impact of victimization.
- Relapse prevention.

Of the 114 treated sex offenders released to date, one has been released for six years; 19 for five years; 19 for four years; 25 for three years; 24 for two years; and 26 for one year.

Of these, 22 committed a non-sex crime after release, and five committed a sex crime. This represents a 96 percent success rate for the specific goals of the sex offender treatment program.

These males are kept under significant aftercare surveillance, and given the three Florida indices used by the program for tracking, it is reasonable to assume that these are fairly accurate statistics.

The long-standing, successful students have said that identification with the victim's pain and suffering, and real progress in anger control and anger channeling, were the parts of the treatment program that made a difference for them.

If even a small percentage of potential adult pedophiles can be diverted into normality by successful juvenile treatment, the benefits for the community will be awesome, considering the impact of sex crimes on the victims, the huge emotional and financial costs of treating victims and the financial cost of prosecuting, confining and treating pedophiles over the course of their entire lives. ■

Wallace A. Kennedy is clinical professor of psychology at Florida State University and chief of staff of the specialized treatment program at the Arthur G. Dozier School. Marie P. Hume is a clinical assistant professor at Florida State University and the Arthur G. Dozier School. For more information, contact Kennedy at (850) 878-3571.

Assessing and tracking the offender

The psychological test battery used by the Florida State University Specialized Treatment Program consists of the Wechsler Intelligence Scale - Revised; the Wide Range Achievement Test - 3rd Edition; the Rotter Incomplete Sentence Blank; the Million Adolescent Clinical Inventory (replacing the MMPI-A, which correlated with neither treatment outcome nor recidivism); the Seriousness of Sex Offending Behavior Scale; the Hare Psychopathy Check List; the Piers-Harris Self-Concept Scale; and the Matson Evaluation of Social Skills in Youngsters.

Students with severe mental retardation were excluded — since the program has a minimal cognitive requirement — as were students nearing their 19th birthday, a milestone that requires discharge of an offender unless the court has extended his stay to the end of a year of treatment.

Some students require several attempts to complete the program in order to work through their resistance. Judges tend to be extremely cooperative in extending commitment time because of the social and political consequences of recidivism.

On very rare occasions a student cannot, or does not, complete the program during a 15-month period. These students are recommended for placement in another treatment program or for transfer, if age 19, to the adult prison system. The statistics for recidivism in this very small group is alarming: almost 100 percent.

In following discharged offenders, Wallace A. Kennedy, Ph.D., used the databases of the Florida departments of Juvenile Justice, Corrections and Law Enforcement. Because of this careful tracking, we believe that any unreported repeated crimes of our graduates occurred only after their aftercare was complete, or in another state, and were not prosecuted. There is good reason to believe that the legal community and families of the victims and the perpetrators are hyper-vigilant regarding recidivism; thus, reporting on these graduates is significantly above that of first-time offenders.

Guest Commentary

Looking for 'smarts' in all the wrong places

By Robert J. Sternberg, Ph.D.

During a trip to Jamaica, I had the opportunity to visit several elementary schools in relatively poor areas of the island. The physical layout of the schools was different from that to which most of us are accustomed. They were large, one-room schoolhouses.

Teachers and their students were arrayed around the room, usually with no partitions separating one class from another. Thus, students got to listen not only to their own teacher's lecture, but to all the other teachers' lectures as well. If students had the misfortune to sit near the side or back of the class, they often could hear another teacher better than they could hear their own. Indeed, I'm sure it was a challenge to make out what their own teacher was saying.

I found myself reflecting on the problem posed to Alfred Binet almost a century ago. If one wished to construct tests to predict school achievement, what kinds of test items might one construct?

I found myself reflecting on the problem posed to Alfred Binet almost a century ago. If one wished to construct tests to predict school achievement, what kinds of test items might one construct?

I decided that, in the typical Jamaican setting, two of the most useful kinds of test items would measure not skills like vocabulary or arithmetic or spatial visualization — the kinds of things Binet measured — but auditory acuity and auditory selective attention. One needed auditory acuity to hear what the teacher was saying, and auditory selective attention to filter out the teachers whose voices competed with one's own teacher.

The test would probably predict school achievement as well, because instruction and even testing were conducted in the same setting, so a student would need the same skills to do well on an auditory ability test, in the classroom, and on orally administered tests of achievement.

I believe that schools in other parts of the world, including the United States, echo the Jamaica situation, without being aware of it. In most schools, two kinds of abilities are at a premium: memory abilities and, to a lesser extent, abstract analytical abilities (those abilities used to analyze, judge, evaluate, compare and contrast fairly abstract concepts).

The ability tests measure these skills, learning from instruction requires them, and then achievement tests assess the degree to which the abilities have been applied successfully. People who do well on the ability tests tend to do well in school, and vice versa, because both settings require similar abilities.

But what matters in real life?

The problem is that these abilities are not necessarily the ones that matter most in the life activities for which school is supposed to prepare our children. How many times have you had to memorize a book or a lecture on your job? How many times have you had to remember the theorems you learned in plane geometry? How many times have you seen the extremely obscure words that often appear on vocabulary tests?

Jobs require memory and abstract analytical skills to some degree, but they also require other skills. It is no surprise, therefore, that even supporters of current tests who are as traditional as Richard Herrnstein and Charles Murray show themselves to be in their book *The Bell Curve*, admit that conventional tests predict only about 10 percent of the variation among people in real-world measures of success. What happened to the other 90 percent?

"Successful Intelligence"

In my book, *Successful Intelligence* (Simon & Schuster, 1996), I argue that intelligence in everyday life requires a broader range of abilities than is measured by conventional tests. The problem with these conventional tests is that they spotlight children who have certain abilities (especially memory and abstract-analytical ones), but leave children with other kinds of abilities, such as creative and practical ones, in the dark.

Children with other kinds of intelligence may be derailed from the fast track early in life, with the result that they never get the opportunity to show what they can really do. Not only do we disenfranchise these children, but we provide almost limitless opportunities for those individuals who do not necessarily have the broader range of abilities they will

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need to take advantage of the opportunities they receive.

In order to help remedy this situation, I have worked with colleagues at Yale to develop a group-administered research version of what I call the Sternberg Triarchic Abilities Test (STAT). There are two levels currently available at cost for research purposes -- one for children at the high school level (roughly ages 15-18) and one for children at the fourth-grade level (roughly ages 9-10). The test measures the conventional kinds of abilities, but other abilities as well.

One-third of the test measures the kind of memory and analytical abilities evaluated by conventional tests of intelligence and scholastic abilities. Another third of the test measures abilities more germane to creative thinking and coping with novelty — the ability to think in novel ways. And the last third of the test measures practical abilities of the kinds needed to adapt to everyday life.

The three kinds of abilities — memory-analytical, creative and practical — are each measured in four different ways: via (1) verbal, (2) quantitative, (3) figural multiple-choice items and (4) essays. The multiple-choice items are objectively scored and the essay items are subjectively scored via trained raters (who are taught to focus on the abilities being measured and ignore irrelevant attributes, such as spelling and punctuation).

The goal is to obtain a more nearly complete picture of a child's abilities than would be possible from a conventional test.

The memory-analytical section looks pretty much like a conventional test, requiring students to figure out meanings of words in context (verbal), complete number series (quantitative) and complete figural matrices with a missing term (figural). The high-school level analytical essay requires students to anlayze the advantages and disadvantages of armed security guards in schools.

The creative section is less conventional, requiring students to solve verbal reasoning problems with counterfactual premises (e.g., what would the solution to this analogy be if money fell from trees?); solve quantitative problems with new mathematical operators (e.g., flix: A flix B = A+B, if A is greater than B; and A-B if A is less than or equal to B); and complete figural series with unusual mappings. The high-school creative essay asks the student the design of an ideal school.

The practical section requires that students solve verbally presented everyday problems faced by typical high-school (or elementary-school) students, solve practical quantitative problems involving recipes, train schedules or purchase of athletic-event tickets, and plan routes using (figural) maps. The high-school practical essay requires students to describe a problem they have and three practical solutions to it.

The test is reliable and predictively valid. In a study of a summer program at Yale, we found that the analytical, creative and practical sections all predicted achievement in a high-school psychology course (taught to value analytical, creative and practical abilities). In our study, the best predictor was analytical abilities and the poorest, practical. In a replication performed by Deborah Coates at the City University of New York with poor, African-American children, the pattern of prediction was reversed, with practical thinking giving the best prediction and analytical thinking the poorest.

We also found that students who were placed in an instructional program that matched their pattern of abilities outperformed those who were mismatched. In other words, if students are taught in a way that at least partially values their strengths, they perform better than if they are taught in standard ways that value the same abilities — namely, the memory and abstract-analytical ones.

To effect change in education, we need not only change the ability tests, but the instruction and the tests of achievement as well. When we emphasize all three kinds of abilities rather than just one, we will find that many of the students who now seem rather inept actually have abilities that, under traditional systems of testing and instruction, remain hidden and ultimately go to waste. We can make the change. Do we have the will? ■

Robert J. Sternberg is IBM professor of psychology and education at Yale University.

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ISSN 0898-2562

The Brown University Child and Adolescent Behavior Letter

Providing the link between behavioral research and your clinical work.

Special Issue: Learning Disabilities

A teacher's view: Inclusion has helped everyone involved

By Ann D. Lipsitt, B.A.

Those of us with the power to use terms such as "deficit," "disorder" or "disability" often apply them with a lack of regard for how that labeling might affect the labeled individuals. Sometimes it feels like name calling.

These words are loaded with negative connotations, and can be easily misinterpreted. As soon as we hear them, we focus on what the person *can't* do.

I was particularly concerned that students placed in these self-contained classes were not expected to be successful academically, behaviorally or socially.

While labels do indeed help us determine what teaching or therapy strategies may be most helpful, they also perpetuate the myth that people who have been "diagnosed" are inferior, based on the absence of an ability.

As a special educator, I have had the opportunity to meet many unique individuals with more similarities than differences. However, most of the students I have worked with have been diagnosed with a variety of "disabilities." I say most of the students, because I have made a strong attempt over the years to help bridge the gap between special education and regular education. I have done so in a variety of ways and for several reasons.

When I started teaching, it was expected that students with significant special needs would be placed in segregated special education classrooms. I noted at that time that these students didn't have access to the same opportunities as

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What to do if your child has a learning disability

A mother's view: A learning disability serves as a lesson in redefining success

By Judith Harkness Richardson, B.A.

What does it take to be successful in life? That is a question that has been much on my mind in the last few years, ever since my only child, now 13, was diagnosed with a significant language-based learning disability as well as attention deficit disorder.

At the time, it seemed impossible for my husband and me to believe that Nick, then a beautiful, bright-eyed first grader, was anything but perfect. Finding out that our child had an invisible handicap that set him apart from other children, that he would require special schooling in a special environment and intensive language therapy, was one of the most painful things either of us has ever been through.

For a long time, I wondered if Nick would ever lead a happy, fulfilled, successful life. How could he when language — that most crucial of all human skills — was for him a constant challenge? And it was not just *written* language that he had trouble with (the most common form of dyslexia) but spoken language as well. What had always struck me as an unusual difficulty understanding directions and telling stories turned

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Editor: Lewis P. Lipsitt, Ph.D.
Professor Emeritus of Psychology, Medical Science, and Human Development at Brown University

Contributing Editors:

Stephen L. Buka, Sc.D., Associate Professor, Department of Maternal and Child Health, Harvard University School of Public Health

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A researcher's view: Learning-disabled children get lost in definitions

By Stephen L. Buka, Sc.D.

A new version of the Individuals with Disabilities Education Act (IDEA) was reauthorized by Congress and signed into law by President Clinton on June 4, 1997. First implemented in 1975 as the Education for All Handicapped Children Act, the law is intended to ensure that children with disabilities have access to a free, appropriate public education, and to improve educational results for children with disabilities.

The IDEA amendments of 1997 are intended to strengthen academic expectations and accountability for the nation's 5.8 million children with disabilities.

A broad range of childhood disabilities is covered, including mental retardation, hearing impairments, speech or language impairments, visual impairments, serious emotional disturbance, orthopedic impairments, autism, traumatic brain injury, other health impairments and specific learning disabilities.

The definition of learning disability (LD) is essentially unchanged from federal regulations of the past 30 years. For purposes of this critical legislation, specific learning disability means "a disorder in one or more of the basic psychological processes involved in understanding or in using language, spoken or written, which disorder may manifest itself in imperfect ability to listen, think, speak, read, write, spell or do mathematical calculations."

Included are conditions such as perceptual disabilities, brain injury, minimal brain dysfunction, dyslexia and developmental aphasia. Learning problems that are primarily the result of visual, hearing or motor disabilities, of mental retardation, of emotional disturbance, or of environmental, cultural or economic disadvantage are not included. These, then, are the legal definitions that determine which children will and will not receive special education services in the years ahead.

Contrast this broad language with definitions used in medical settings. The fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) states that learning disorders "are diagnosed when the individual's achievement on individually administered, standardized tests in reading, mathematics or written expression is substantially below that expected for age, schooling and level of intelligence" and when the learning problems "significantly interfere with academic achievement or activities of daily living that require reading, mathematical or writing skills."

Reading disorder, alone, accounts for four of every five cases of learning disorder. Dyslexia, the most common of learning disabilities, has been defined even more narrowly as "a specific language-based disorder of constitutional origin characterized by difficulties in single word decoding, usually reflecting insufficient phonological processing abilities. These difficulties in single word decoding are often unexpected in relation to age and other cognitive and academic abilities;

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they are not the result of generalized developmental disability or sensory impairment." (operational definition of the Orton Dyslexia Society Research Committee, April 18, 1994).

Many recent scientific advances have resulted from such stringent definitions of dyslexia. Brain imaging studies now identify critical brain regions (primarily in the left cerebral hemisphere and planum temporale), identification of a core phonological processing deficit, evidence of genetic factors for both family history of reading disorders and phonologic deficits, and sophisticated new educational technologies.

We have a mismatch here between the definition of learning disabilities under the IDEA legislation and the conditions found, treated and studied in medical and research settings. They are not the same children.

In a study that I and my colleagues did of 230 adolescents seeking treatment for chemical dependence, 11 percent (26 subjects) had been diagnosed as LD by their schools. However, only six of these met formal test-based criteria. Similarly, only 13 percent of those meeting test-based criteria were diagnosed by their school systems.

Sally Shaywitz, M.D., and others at Yale University followed a representative sample of Connecticut public kindergarten students into the second grade (and beyond). By second grade, the schools had identified only half as many girls as reading-disabled than did standardized test procedures, but twice as many boys.

A valuable strategy for determining which children have a true disability is to conduct longitudinal studies, examining the persistence of deficits and associated difficulties of daily living over time. At UCLA, Paul Satz, Ph.D., reviewed the quality and results of 33 follow-up studies of children with LD. A few central findings from this work warrant mention.

The reputed connection between early learning disabilities and later antisocial behavior and emotional disorders is not well-supported.

First, irrespective of how childhood learning problems are defined, these studies demonstrate that the academic outlook for children with early learning problems is poor, unless a child comes from a high-income family and/or participates in high-quality educational remediation programs. Second, children with early LD are more likely to drop out of school. Third, the reputed connection between early learning disabilities and later antisocial behavior and emotional disorders is not well-supported.

Such studies can contribute greatly to current debates around the definition of LD, including potentially harmful effects of labeling and mislabeling. Is the long-term prognosis for certain forms and definitions of LD worse than for others? Are certain forms of LD more likely to persist across the life course than others? As for other forms of disorder, shouldn't we reserve the term "disability" for chronic or persistent conditions that have a poor prognosis? There are several ongoing studies worldwide that will help resolve these questions.

In addition to the Connecticut study, Lewis P. Lipsitt, Ph.D., and colleagues at Brown University are reinterviewing a sample of 500 children with test-defined LD and 500 non-LD children in adulthood, at age 35. In addition to those with early reading problems, children with problems in writing (dysgraphia), arithmetic (dyscalcula) and spelling complete a full battery of neuropsychological, educational and cognitive tests as well as detailed life history interviews.

Preliminary results do indeed indicate that school systems overdiagnose LD in boys and underdiagnose girls. This may account for the worse prognosis observed in this study for girls with early LD. Ongoing results from these studies should help bring together scientific advances with legislative mandates such as the reauthorization of IDEA, further ensuring that those children with the most severe forms of LD do indeed receive the free and appropriate education to which they are entitled. ■

Stephen L. Buka, Sc.D., is associate professor, Department of Maternal and Child Health, Harvard University School of Public Health, and a member of the *CABL* editorial board.

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Keep Your Eye On

... sudden infant death syndrome.

Babies who die of sudden infant death syndrome (SIDS) may have lower levels of a neurotransmitter, kainate, than babies who die of other causes, according to new research.

Hannah Kinney, M.D., and colleagues at Children's Hospital and Harvard Medical School in Boston performed autopsies on 79 babies who had died of SIDS. Compared to infants who died of other causes, the SIDS babies had 52 percent less kainate in the arcuate nucleus region of the brain, which helps control breathing and blood pressure. The findings suggest that as carbon dioxide levels rise and oxygen levels fall during sleep, the brains of some babies may not compensate by receiving the correct signal to alter their breathing or blood pressure. The researchers had found in earlier research that SIDS babies had less activity at the second point where neurotransmitters attach to brain cells, called muscarinic cholinergic receptor (mAChR).

"This finding is exciting in that it confirms our earlier discovery of the mAChR receptor, and strengthens the argument that a deficit in the arcuate nucleus — specifically in two receptors involved in signaling neurons — may be partially responsible for some SIDS deaths," Kinney says.

SIDS is the leading cause of death in infants age one month to one year in developed countries, according to the National Institute of Child Health and Human Development, which funded Kinney's study. Placing infants on their backs has been shown to dramatically reduce the incidence of SIDS, possibly because when infants are on their stomachs, they rebreathe air trapped in bedding.

"We think this new finding fits in with the rebreathing theory — that infants sleeping in the prone position are rebreathing trapped air and, unable to sense and respond to the excess carbon dioxide, die suddenly," says Kinney. (Reuters)

What's New in Research

Are stimulants appropriate for conduct disorders?

Stimulants traditionally have not been considered appropriate treatment for conduct disorders in children. But a recent study of 84 children who were randomly assigned to receive either placebo or 60 mg daily of methylphenidate (Ritalin) for five weeks found the drug did make a difference. The children, ages 6 to 15, had their behavior evaluated by parents, teachers and clinicians and by direct classroom observations. Two-thirds of the children in the study met the criteria for attention-deficit/hyperactivity disorder (ADHD) as well as conduct disorder (CD).

Ratings of antisocial behaviors specific to CD were significantly reduced by methylphenidate treatment. Even when controlling for severity of ADHD symptoms, the superiority of methylphenidate on CD ratings did not change.

The researchers conclude that methylphenidate has short-term positive effects on children and adolescents with CD, and that some aspects of antisocial adjustment appear to be responsive to the treatment as well.

"Clinical efficacy of methylphenidate in conduct disorder with and without attention deficit hyperactivity disorder," R.G. Klein, Ph.D., et al., *Archives of General Psychiatry* 54:1073-1080, 1997. For reprints, contact Dr. Rachel G. Klein, Ph.D., Department of Clinical Psychology, Unit 80, New York State Psychiatric Institute, 722 West 168th St., New York, NY 10032.

'Social capital' influences children's prosperity

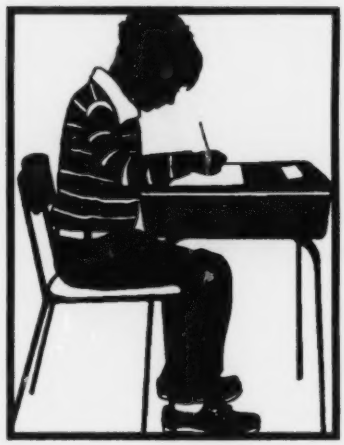
Recent research found that social capital — the benefits derived from personal social relationships within families and communities — appears to have a great impact on preschoolers, and that it appears to be the parents' social

Recommended Reading

BRIEF INTERVENTION FOR SCHOOL PROBLEMS: COLLABORATING FOR PRACTICAL SOLUTIONS — *John J. Murphy & Barry L. Duncan, Guilford, New York, 175 pages, $26.95 (hardcover); (800) 365-7006.*

This empirically oriented book provides helpful instruction in short-term intervention with children having school problems. The authors approach the task with the following convictions: (1) Students are valuable intervention consultants. (2) Students, parents and teachers often have the ideas, competencies and resources required to resolve their school problems. (3) Big problems do not always require big solutions. (4) Important and lasting changes can occur quickly.

What to do if your child has a learning disability



The first step is an accurate assessment.

If your child isn't doing well in school, or isn't doing as well as he could, he may have a learning disability. But there are many different kinds of learning disabilities, and it could just as easily be something else, such as anxiety, or a reaction to a divorce, or near-sightedness. The only way to be sure your child has a learning disability is to have him tested.

Reliable diagnostic tests that take into account a child's social, psychological and educational levels can give you a whole picture of his functioning, says Vicki Newell of the Learning Disabilities Association of New York City.

Newell, who is the association's client and resource manager, fields phone calls from concerned parents. She tells them that learning-disabled people have average or above average intelligence. "A learning disability doesn't mean someone is mentally retarded," she says.

Nor does it mean that a child who takes a little longer to understand long division has a learning disability. "Children learn at different rates," says Newell. "Some are fast learners; some are slower."

However, if you or your child's teacher suspect that a problem goes deeper than individual variations in learning, it's best to get a diagnostic assessment and decide where to go from there.

Some parents are reluctant to have their child tested, out of fear that he or she will be stigmatized among peers and teachers. "The child doesn't walk around with 'Learning Disabled' written on their forehead," Newell says. "It isn't the shameful thing it once was."

Once the exact nature of a child's problem is identified, you and your child's school can collaborate on a plan that will best facilitate his or her learning.

That doesn't necessarily mean special education classes, says Newell. Sometimes special arrangements can be enough, such as allowing the child extra time to take a test. The Individuals with Disabilities Education Act gives parents the right to have their learning-disabled children educated in their own school system.

In some school systems, parents who feel that their child is not getting the appropriate services can ask for an impartial hearing, or go to mediation. The legal nuances of special education can be "absolutely overwhelming," says Newell, adding that groups such as the Learning Disabilities Association can help parents advocate for their children.

She says that parents who find out that their child is learning-disabled go through a

... Continued on next page

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similar process as do parents of children with other long-term disabilities: first, denial; then, "why me?"; and, finally, acceptance.

"Once you know your child has a learning disability, it's there all day, and you have to learn the best way to deal with it," Newell says. "Sometimes it's repetition — going over something over and over until it clicks. You have to be patient, and it's no easy thing."

The parents who call the Learning Disabilities Association often take on too much themselves, she says. Sometimes, taking a step back, such as hiring a tutor, can be the best thing for everyone.

A new book guides parents of children with learning disabilities through the process of identifying the disability to developing an educational program. *Learning Disabilities: A to Z* (Free Press, $25), by Corinne Smith and Lisa Strick, shows that parents, far from being helpless, are the most important advocates for their children.

For more information, contact the Learning Disabilities Association of America at (412) 341-1515.

The Brown University **Child and Adolescent Behavior Letter**

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capital that provides the greatest benefit to their children. Furthermore, social capital appears to be most important for families with fewer financial and educational resources.

The research was designed to examine the extent to which social capital is associated with positive developmental and behavioral outcomes in high-risk preschool children.

In this consortium study, researchers identified 667 two- to five-year-old children and their maternal caregivers who were considered to be living in unfavorable economic or social circumstances. A social capital index was created, assigning one point to each of the following indicators:

- The children had two parents or parent-figures in the home.
- The maternal caregiver had adequate social support.
- There were no more than two children in the family.
- There was neighborhood support.
- There was regular church attendance.

Outcomes were measured with the Child Behavior Checklist and the Battelle Developmental Inventory Screening Test. If children had scores on those instruments indicating neither behavioral nor developmental problems, they were classified as doing well.

However, only 13 percent of the students were found to be doing well. The indicators that were most likely to discriminate between levels of child functioning were church affiliation, perception of personal social capital and support within the neighborhood. But the presence of any social capital indicator increased by 29 percent the odds that children would do well.

The researchers say that new and creative ways of supporting interpersonal relationships and strengthening communities must be found in at-risk families.

"Children who prosper in unfavorable environments: The relationship to social capital," D.K. Runyan, M.D., Dr..P.H., et al., *Pediatrics* 101:12-18, 1998. For reprints, contact Dr. Desmond K. Runyan, Department of Social Medicine, CB# 7240, University of North Carolina School of Medicine, Chapel Hill, NC 27599-7240.

Resources

Search Institute releases book on community

The Search Institute is a nonprofit organization dedicated to advancing the well-being of children and adolescents. Its new book, *All Kids Are Our Kids*, written by institute president Peter L. Benson, contains advice on asset-building for adults, removing stereotypes when building relationships with children and adolescents, and mobilizing youth and adults for community action one-by-one. For more information, write to The Search Institute, 700 S. Third St., Suite 210, Minneapolis, MN 55415; or call (800) 888-7828.

A teacher's view
from page 1

the students who participated in regular education classrooms. Their curriculum was watered down and did not provide exposure to the real world. Their school environment was isolating, and they had only each other as role models and peers.

I was particularly concerned that students placed in these self-contained classes were not expected to be successful academically, behaviorally or socially. Along with many other special educators in the early 1980s, I worked toward creating a more integrated model of education and pushed for all students to participate within the mainstream.

Vermont has taken the lead in the effort toward mainstreaming and has been cited for its exemplary innovations. I have had the good fortune to witness the positive changes that have occurred. As students began to be mainstreamed into a few classes, I also found myself moving out of my isolated classroom, working together with the rest of the staff. Teachers, administrators and special educators met regularly to talk about students' needs, abilities and differences.

Initially this was a very challenging process. Helping others see the benefits of having children in their schools and classes who were significantly different from the students they were accustomed to teaching was the biggest hurdle.

I'd like to believe that those of us involved in the early integration of students with significant learning differences were great at convincing others of the benefits of these changes. But this was not the case. While the adults were instrumental in making schools welcoming and supportive, the students themselves have been the greatest teachers. As more students began attending classes in local communities, significant changes began to take place in both their schools and their communities.

Vermont schools were already providing for learning-disabled students in the form of small-group instruction taught by special edu-

cation staff. The precedent had already been set for inclusion. We were now just expanding the concept of who would be included in our local schools. Over the years we have learned that inclusion is a complex process calling for a variety of solutions that include a blend of mainstreaming and individualized instruction. I believe that through exposure, experience and education, we have helped people become more accepting and tolerant of individual human differences.

Especially impressive is the rapidity with which our students have developed their sensitivities to others. I recall one middle school student, Steven, who had a multitude of tics. He was diagnosed with Tourette's syndrome (TS) and written language and mathematical learning disabilities. Steven's ticking behaviors were frequent and included loud noises, throat clearing and head and eye movements. However, he was in total denial of the fact that he was different. He would not discuss with anyone that he manifested behaviors that were unusual and, interestingly, he insisted that he did not have TS.

Each year, classroom teachers and special educators spoke with Steven's classmates, explaining TS, answering questions and helping to eliminate the concerns and fears of the other students. Steven never wanted to be included in these discussions. Although some teasing occurred, few incidents among students were noted by the teachers. Instead, whole classrooms of students learned to live with these noises and accepted Steven into the group, becoming oblivious to his difference. In the process of assimilating Steven, it became apparent that the adults were the ones doing the talking, and their talk tended to convey fear, annoyance and concern for themselves and their students.

Through discussion, experience and personal contact, the whole school became a more accepting environment where some loud, interrupting noises and unusual physical movements became acceptable. This was Steven, a child who ticked, not the student with TS.

One strategy I adopted to help bridge the gap between regular education and special education can be termed "reverse mainstreaming." I stopped teaching exclusively homogeneous classes and began teaching a few heterogeneous reading and writing classes. Thus, my classroom stopped being just a special education classroom, except in the sense that everyone there was special. Team teaching between special educators and regular educators has also significantly changed the school environment, making it more like the world found in local malls, grocery stores and libraries — an inclusive community represented by a complete spectrum of the human condition.

When schools and local communities include all of their members, all individuals have the opportunity to know and feel that they belong. When we segregate some individuals through the words we use, along with other exclusionary practices, we imply that some people are not good enough to be a part of the whole community. The language we use to describe individual differences to each other can have a lasting, humanizing effect on how we treat each other. A disability — or difference — is just one part of who a person is. It's not the person's identity. A person with a disability is not a disabled person. ■

Ann Lipsitt is a special educator in Underhill, Vt. A 1993 recipient of The Outstanding Vermont Teacher Award for excellence in teaching and devoted service to Vermont youth, she has been teaching for 18 years.

A mother's view

from page 1

out to be a pervasive processing disorder, both auditory and expressive. This, combined with difficulty paying attention, made his educational outlook dim. It seemed unlikely that Nick would excel in school, learn to love books and reading or go on to a top-notch college and a career in a traditional field, such as medicine or the law — all accomplishments that, somewhere deep inside, I believed to be indispensable to a successful life.

Much has happened in the years since that time, both to us personally and in the world of research. The human brain — that uncharted frontier — is finally being explored and mapped. Although there is still much to learn, great strides have been made in the last decade. We now know, for example, that the human brain has the capacity to rewire itself during the first few years of life. Children who have suffered seemingly irreversible damage to one portion of the brain have been shown, in a number of scientific investigations, mysteriously to recoup the functions normally controlled by the injured portion. Neuroscientists have concluded that the brain, which

continues to change and mature through the first years of life, has in some instances been able to reroute these functions to other neurological centers. Children presumed never to be able to walk, talk or interpret visual images have learned to do so.

The research of Paula Tallal, Ph.D., co-director of the Center for Molecular and Behavioral Neuroscience at Rutgers University, offers specific hope for language-learning impaired children. Tallal based her work on the landmark studies of Dr. Michael Merzenich, which found that even in adult monkeys the brain can reshape its neural circuitry in response to environmental experiences. By applying this finding to their studies of children with language-processing disorders, Tallal and Merzenich discovered that the neurons that govern auditory processing could be trained, using computer games and listening exercises. Using these methods in two separate studies, they produced stunning results: After children received just four weeks of intense training with computer games, their scores improved by an average of two years developmentally.

Surely these discoveries offer the strongest possible argument in favor of early and strong intervention for children with language disabilities. They also help to explain why Nick, enrolled for the last seven years in small schools that specialize in educating bright children with learning problems (the Hamilton School at Wheeler in Providence, R.I., and St. Andrew's School in Barrington, R.I.) and working with language therapists once or twice a week, has raised his expressive and auditory-processing skills from well below average to average or, in some cases, well above average. The child who at the age of six had trouble finding the right word for the visual image of a shelf now comes up with three or four synonyms for a wide range of images. What seems far more important, from the point of view of a young adolescent, is that he is no longer teased by his classmates for using inappropriate words or taking hours to tell a simple story. While Nick may never be an avid reader like his parents, his reading skills are adequate. And surprisingly, for a child who has struggled so much with words, he is turning out to be an inventive and expressive writer. All those years, when we wondered if the special schools and therapy were anything more than money down the drain, turned out to have been well-spent, after all.

I am just beginning to realize that while I have always related intelligence to verbal agility (something that always came easily to me), there are forms of intelligence I am too dumb to even imagine.

Of all the strides we have made in the last few years, however, I cannot help feeling that one of the most important has been in the realm of attitude — my own included. As a society, we have always valued most those skills that help us survive and prosper. In the 16th century, the ability to sit and listen for hours at a time was highly prized: You could not survive a single Sunday sermon without it, and before the advent of mass publishing, there was no other way of passing along knowledge from one generation to the next. With the invention of the printing press, reading and writing became the chief means of transmitting information, and the skills needed for those activities grew in value.

In a linguistic society, a child who struggles with language, no matter how talented in other areas, is automatically labeled "handicapped." If he has trouble sitting still in class and listening attentively, he is considered at least a nuisance and, more often, a troublemaker. These are de facto misbehaviors that require remediation and possibly medication. And yet, as cognitive behavioral psychologist Philip Kendall of Temple University points out, "Behaviors that are commonly regarded as troublesome in grades one through six, such as clowning, an excess of energy and impulsivity, may become assets in adulthood, becoming the earmarks of the highly successful entrepreneur or entertainer." Similarly, it may be that a child with special visual, musical or conceptual gifts who struggles with the linear and linguistic work predominant in today's classrooms will have an edge over his peers in the not-so-distant future.

I am just beginning to realize that while I have always related intelligence to verbal agility (something that always came easily to me), there are forms of intelligence I am too dumb to even imagine. I am speaking now about such things as the spatial acuity that allows some people (like my husband, an architect, as well as our son) to be able to read a two-dimensional drawing in 3-D, or to solve three-dimensional puzzles with the speed of light. This is a gift that, according to some thinkers, will become more and more valuable as visual imagery, led by the film industry and computer graphics, becomes increasingly sophisticated and central to communication while the written word steadily loses its primacy. And it's a

Commentary

People are mostly the same

A now-unknown sage said: "We humans are all very much the same, but those differences that exist are powerfully important." We don't know any longer whether he or she was referring to sex differences, the differences between children and adults, race differences, adult stature differences, colorblindness, differences in shyness vs. an eager approach to relationships with others, or differences in perceiving and learning styles. It probably doesn't matter, because the generality pertains to all of these and more.

Just how powerfully different those idiosyncrasies are can be best visualized if we think of how most people are born with a head that is positioned atop the body, containing a face that has two eyes, a nose and a mouth. Any person or picture of a person is immediately recognizable as a human — a member of our own species and rather like our own family of origin. Yet, only one person (usually) looks just like our own mother or sister or uncle.

You can pick your mother out of a crowd at a very young age. Even eight-month-olders worrying about mother's whereabouts can change into instantly delighted babies upon spying their very own mother's familiar face. As an adult, if you are shown pictures of 1,000 faces, you will on demand select your mother from the batch. That there are a million — or 100 million — faces that are recognizably different is itself a great fascination of human nature in its love of individual differences.

If people can be that varied, that distinctive, in their anatomical structures, and thus in appearance, even while remaining mostly the same, imagine the distinctions that must exist among them in the vastly more complex architecture of the brain and the rest of the central nervous system. The numbers and types of neurons are astronomical, and the information they carry — mediating thought, learning, reflexes, feelings and the myriad of dispositions that individuals bring to the world — is staggering.

I find this kind of exercise especially helpful in understanding and appreciating learning disabilities, or better, learning differences, or to use the term I like best, learning distinctions.

Sometimes we can better comprehend major differences in the human capacities of integrating thought, making plans, using symbols such as numbers and letters and words, engaging in complex physical maneuvers or bonding with others, by observing and talking with individuals whose burden of distinction is severe and handicapping. A major aspect of the handicap has to do with the effect that the condition has on others. An especially sad situation arises in families that feel stigmatized (or are in fact stigmatized) in unaccommodating school environments.

We have devoted almost the entire issue of this month's *Brown University Child and Adolescent Behavior Letter* to the very important matter of "learning distinctions" among children and adolescents. We take heart in the fact that some excellent research is being done in the United States, both to understand the origins of handicapping learning styles and to document the developmental consequences of variations in teaching and learning. We hope especially that those who are working the front lines with individuals who are seriously affected, sometimes quite deleteriously, by benign neglect will see that the disciplines of child development and education are coming to realize, finally, that the field of special education is indeed very special.

Lewis P. Lipsitt

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gift that language-impaired children seem to possess with remarkable frequency.

I will continue to do my best to help strengthen the skills in which Nick is weak, but I have learned something new. If you had asked me 10 years ago to define what I thought was crucial for my son's success, I probably would have answered, "becoming as much as possible like other children." Today, I would have a different answer. It would be, "accepting and valuing him for who he is, and for his very special gifts, which may be very different from my own, and difficult for me even to understand, but which he must be encouraged to nurture and protect."

And perhaps that is what being a parent is all about, anyway. ■

Judith Harkness Richardson, a writer, is the mother of Nicholas Richardson, who attends St. Andrew's School in Barrington, R.I.

ISSN 0898-2562

The Brown University Child and Adolescent Behavior Letter

Providing the link between behavioral research and your clinical work.

Parenting

To be successful, community programs must involve parents in a meaningful way

By Peter Ernest Haiman, Ph.D.

Securing and maintaining active parent involvement should be a top priority of educational and social service programs. Child care centers, social service agencies and elementary and secondary schools help meet the needs of children, adolescents and other family members, but it is the parents who have the most significant and enduring impact. Most private, state and federally funded programs do not, however, have successful parent involvement components.

The interests of the adult within the parent must be accurately assessed and then met or nurtured by education and social service programs.

The attitudes that program administrators and staff have about parents and their involvement are critical. First and foremost, parents are adults. For their involvement efforts to be effective, therefore, programs — while addressing either parents' roles or social service needs — must meet the interests of parents *as adults*. It is imperative that parents trust program administrators and staff to be interested in them *as adults* as well as parents. This trust can form only if program personnel have ongoing meetings with parents both in groups and individually to learn what makes up the adult within each parent.

Whether living in poverty or at higher socioeconomic levels, all parents have a variety of adult interests, abilities, talents and skills that either lie dormant, are ne-

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Vol. 14, No. 3 March 1998

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Fluoxetine reduces impulsive and aggressive behavior.
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Guest Commentary: Brief therapy is effective in some cases, but use with caution.
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This month's client handout
Suicide is not about death

Suicide

Child behavior professionals are not untouched by family suicides

By W. Brian Barr, C.S.W.

On July 31, 1984, my 18-year-old son, Kevin, committed suicide. The pain of hearing that news from the two policemen who came to my door was indescribable, but my wife and I weren't surprised by Kevin's death. He fit the classic profile of a suicide victim. He had tried before, and he had been hospitalized for depression. But what was most humbling about our son's suicide was that I was unable to prevent it. You see, I have spent my entire 30-year professional career working with troubled teenage boys.

Kevin was part of a tragic national trend. Approximately every hour and 40 minutes in the United States, a teenager takes his or her life. That's 6,000 successful suicides per year, making it the second-leading cause of death for teenagers. (The leader is also behavioral: accidents. — Ed.) Almost equally disturbing are the 90,000 suicide attempts each year, proof that across the nation, from inner city to suburb, our youngsters are becoming increasingly depressed. In fact, since 1955, the suicide rate has tripled for

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The Brown University Child and Adolescent Behavior Letter

Editor: Lewis P. Lipsitt, Ph.D.
Professor Emeritus of Psychology, Medical Science, and Human Development at Brown University

Contributing Editors:

Stephen L. Buka, Sc.D., Associate Professor, Department of Maternal and Child Health, Harvard University School of Public Health

Cynthia Garcia Coll, Ph.D., Professor, Education, Psychology and Pediatrics; Chair of Education Department, Brown University

Ferdinand Jones, Ph.D., Professor of Psychology, Brown University; formerly director of Brown University Student Counseling

Dwight B. Heath, Ph.D., Professor Emeritus of Anthropology, Brown University

Carol Landau, Ph.D., Clinical Professor of Psychiatry and Human Behavior, Brown University; private practice

Carol Lewis, M.D., Clinical Instructor in Pediatrics, Brown University School of Medicine; private practice

Theodore R. Sizer, Ph.D., University Professor Emeritus, Brown University; Chairman, Coalition of Essential Schools; former director, Annenberg Institute for School Reform

Sally Zierler, D.P.H., Associate Professor of Medical Science, Brown University School of Medicine

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The Brown University Child and Adolescent Behavior Letter (ISSN 0898-2562) is published by Manisses Communications Group, Inc., 208 Governor St., Providence, RI 02906; 401/831-6020; Fax: 401/861-6370. Yearly subscription rates are $167 for institutions and $117 for individuals. Periodicals postage at Providence, RI. POSTMASTER: Send address changes to: Manisses Communications Group, Inc., P.O. Box 9758, Providence, RI 02940-9758. ©1998 by Manisses Communications Group, Inc. Member, Newsletter Publishers Association. **The Brown University Child and Adolescent Behavior Letter** reports monthly on work in child development. Our purpose is to provide timely, accurate information by drawing on professional journals, expert opinion and the experience of our editors and guest writers. **The Brown University Child and Adolescent Behavior Letter** does not offer medical, legal or administrative services and we encourage subscribers to seek advice from qualified professionals. **The Brown University Child and Adolescent Behavior Letter** is available in reference systems produced by Information Access Company. For more information, contact Information Access Company, Rights & Permissions Dept., 362 Lakeside Drive, Foster City, CA 94404, or call (800) 227-8431 (U.S. only) or (415) 378-5000. All rights reserved. Reproduction forbidden without the consent of the publisher. Authorization to photocopy articles for internal or personal use or the internal or personal use of specific clients, is granted by Manisses Communications Group provided that the fee of $6.00 per article is paid to the Copyright Clearance Center, 222 Rosewood Drive, Danvers, MA 01923; (508) 750-8400.

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What's New in Research

How prevalent is cigarette promotion to public school students?

Dartmouth Medical School researchers in Hanover, N.H., assessed the relationship between smoking behavior and the ownership of cigarette promotional items among 1,265 students in grades 6 through 12 attending five rural New Hampshire and Vermont public schools. Through a voluntary, self-administered survey, they found that one-third of students admitted to owning a cigarette promotional item such as a T-shirt or hat with a cigarette brand logo on it.

Although only 4.5 percent of students reported bringing a cigarette promotional item to school on the day of the survey, 44.5 percent said they had seen such an item that day.

The researchers also found that students who owned cigarette promotional items were more than 4.1 times as likely to be smokers than were students not owning those items, and that students whose friends smoked were 6.7 times more likely to smoke. The most common cigarette logo found on the items was from Marlboro.

The researchers advocate including a ban on such promotional items in the Food and Drug Administration regulations to help prevent tobacco use among U.S. youth.

"Cigarette promotional items in public schools," J.D. Sargent, M.D., et al., *Archives of Pediatrics and Adolescent Medicine* 151:1189-1106, 1997. For reprints, contact Dr. James D. Sargent, Department of Pediatrics, HB 7999, Dartmouth-Hitchcock Medical Center, Lebanon, NH 03766.

Psychosocial problems are more common in hungry children

In a recent study, researchers found that almost all behavioral, emotional and academic problems were more prevalent in hungry children than in children who were not hungry.

Researchers gathered information on 328 parents and children from a Community Childhood Hunger Identification Project (CCHIP) study of families living in the Pittsburgh area with at least one child under the age of 12. All parents with children ages six to 12 were asked to complete a pediatric symptoms checklist — a brief parent-report questionnaire assessing children's emotional and behavioral symptoms. Hunger status was defined by parent responses to the standard eight-food insufficiency questions from the CCHIP survey that are used to classify households as "hungry," "at-risk for hunger" or "not hungry."

Among low-income families, children defined as hungry on the CCHIP were significantly more likely to have clinical levels of psychosocial dysfunction on the pediatric symptoms checklist than were children defined as "at-risk for hunger" or "not hungry." The most common problems found in hungry children were aggression and anxiety.

"Hunger in children in the United States: potential behavioral and emotional correlates," R.E. Kleinman, J.M. Murphy, M. Little, et al., *Pediatrics* 101(1):1-6, 1998. For reprints, contact Ronald E. Kleinman, M.D., Division of Pediatric Gastroenterology and Nutrition, Massachusetts General Hospital, 32 Fruit St., VBK 107, Boston, MA 02114.

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Suicide is not about death

Teens who contemplate suicide don't want to die — they want to find an end to their pain.

Suicide is the second-leading cause of death among 15- to 24-year-olds. Only accidents cause more deaths and many of those are believed to be the result of suicidal impulses. Many studies show that one out of every 10 teens will have attempted suicide by the time he or she reaches high school. Up to 60 percent report that they've had suicidal thoughts or intentions.

Talking to teens about suicide will not give them ideas; for too many, suicide is something they've already thought about. As a parent, you are the most important adult in your teen's life. It is possible for you to make changes that will make suicide an unlikely choice for your son or daughter.

Finding an end to the pain

Suicidal teenagers experience overwhelming feelings of helplessness, hopelessness and worthlessness. They feel there is no hope that they will ever find help or relief for these feelings.

Young people who contemplate suicide don't want to die; they are more focused on finding an end to their pain. Adults all too often dismiss a young person's "troubles," believing that these problems are temporary and will pass. Teens, however, don't have this perspective on life. They feel that the unhappiness they feel now is permanent. They are unable to believe that anyone can help them or that there are alternatives and choices available to them. Young people do not understand that suicide is a permanent solution to a temporary situation.

How you can help

Listen. Be open and willing to hear what your teen has to say. Questions that show interest may help move the conversation along, but avoid giving advice, making judgments and offering your solution for the problem.

Don't give up if your teen tries to shrug you off. Many times, young people need to be convinced that an adult's concern is genuine before they'll open up and talk about their feelings. Listen for the feelings behind the words. Be alert for phrases like "I'd rather die than ..." or "Doesn't it ever get better?" or "It would be better if I weren't around."

If you determine that your teen could be at risk, ask directly, "Are you having thoughts of suicide?" This will *not* put the idea into your teen's head — the signals that caught your attention were already there. Asking this difficult question will open the door for a dialogue about

Continued, over ...

Spot the signs

Unfortunately, there is no "Suicidal Checklist" for parents to consult. However, there are risk factors that may indicate that your teen is experiencing suicidal ideations. Watch for:

- ✓ Any previous suicide attempt or risk-taking behavior or acts of self-harm.
- ✓ Low self-esteem or social isolation.
- ✓ A sense of hopelessness or helplessness.
- ✓ A change in usual behavior and activities.
- ✓ A traumatic event or recent loss.
- ✓ Alcohol or drug abuse.
- ✓ The recent suicide of a friend or family member.

what is going on and give you the chance to help.

Assess the immediate risk

If your teen admits to having thoughts of suicide, it will no doubt be unsettling to both you and your teen. It is critical that you stay calm. Hear your teen out, treat his or her feelings with genuine concern and take them seriously. Try to determine the magnitude of the suicide plan: how, when and where your teen planned to attempt suicide. The more fethal and available the means of suicide, and the more specific the time frame, the greater the risk.

Determine the risk by assessing these factors: Danger + Availability + Time Frame = RISK.

If your teen isn't open to talking with you about these feelings, work together to identify someone he or she is comfortable with: an aunt, uncle, grandparent, neighbor, pastor, friend, school counselor or therapist — anyone with whom your teen can talk, while feeling safe and at ease. ■

Resources

Young people often don't realize how available help can be. There are crisis hotlines in every state that provide confidential support, intervention and referrals. For more information, contact:

The American Association of Suicidology
4201 Connecticut Ave. NW, Suite 310
Washington, DC 20008
(202) 237-2280
www.cyberpsych.org

American Foundation for Suicide Prevention
120 Wall St., 22nd Floor
New York, NY 10005
(212) 363-3500
www.afsp.org

This suicide primer was prepared by Kids Under Twenty One, a St. Louis-based teen hotline. For more information, contact Kids Under Twenty One at 2718 S. Brentwood Blvd., St. Louis, MO 63144; phone (314) 963-7571. Reprinted with permission from the newsletter of *Parenting for Peace and Justice Network*, #77, August 1997. For more information, contact The Institute for Peace and Justice, 4144 Lindell Blvd., Room 408, St. Louis, MO 63108; phone (314) 533-4445; fax (314) 533-1017; e-mail ppjn@aol.com.

The Brown University Child and Adolescent Behavior Letter

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PLACE YOUR BUSINESS CARD HERE BEFORE PHOTOCOPYING

Fluoxetine helps control aggressive behavior

"Fluoxetine treatment has an antiaggressive effect on impulsive aggressive individuals with DSM-III-R personality disorder," say the authors of a recent study.

A double-blind, placebo-controlled trial of fluoxetine (Prozac) was conducted in 40 adult patients with current histories of impulsive aggressive behavior and irritability. Measures used included the Overt Aggression Scale-Modified for Outpatients (OAS-MO) and the Clinical Global Impression Rating of Improvement (CGIRI).

Compared to placebo, patients on fluoxetine had sustained reductions in scores on the irritability aggression subscales of the OAS-MO that were apparent during the second and third months of treatment. In addition, fluoxetine was found to be superior to placebo in the proportion of responders on the CGIRI starting at the end of month one and continuing throughout the three months of treatment.

"Fluoxetine and impulsive aggressive behavior in personality-disordered subjects," E.F. Coccaro and E. Kavoussi, *Archives of General Psychiatry* 54:1084-1088, 1997. For reprints, contact Emil F. Coccaro, M.D., Clinical Neuroscience Research Unit, Department of Psychiatry, MCP Hahnemann School of Medicine, Allegheny University of the Health Sciences, 3200 Henry Ave., Philadelphia, PA 19129.

Resources

Videos focus on teaching social skills to youngsters

The Bureau for At-Risk Youth has developed five motivational videos under its "Kelly Bear" character education program for youngsters who are in pre-kindergarten through third grade. The videos feature a life-size green bear named Kelly, who serves as a teacher and hero to five children. Videos include additional youngsters who interact with the author in a classroom, playgroup and home setting. The videos focus on teaching vital social skills such as respect, friendship, anger management and refusal skills. For more information, write to The Bureau for At-Risk Youth, P.O. Box 760, Plainview, NY 11803-0760; or call (800) 999-6884.

Guide addresses OCD in children, adolescents

A patient guide from the University of Wisconsin-Madison Department of Psychiatry on obsessive-compulsive disorder (OCD) in children and adolescents is available. The guide contains chapters on commonly asked questions about OCD in children; children and adolescents with OCD at school; treatments for OCD; anti-OCD medications and their side effects; and OCD and the family. The cost of the 57-page booklet ranges from $4.50 per copy for one to nine copies to $2.50 per copy for more than 50 copies. For more information, write to the Dean Foundation, 2711 Allen Blvd., Middleton, WI 53562; or call (608) 827-2390.

Applications for fellowships now being accepted

The Center for Young Children and Families at Teachers College, Columbia University, New York City, is holding its sixth summer fellowship program for doctoral students. "Putting Children First," a fellowship training program in child and family policy with a developmental perspective, links academic learning across disciplines with interests in social policy. In cooperation with the Society for Research on Adolescence and the Society for Research in Child Development, the program has full-time placements for eight weeks in New York City government and nonprofit agencies. Fellows also attend weekly seminars at Columbia University's Center for Young Children and Families. The application deadline is April 3. Fellowships begin June 1. Fellows receive a $2,800 stipend and a $250 travel grant. Financial assistance is available for housing. To apply, send a three-page statement describing your interests in policy and research and a current resumé to Lisa O'Connor, Center for Young Children and Families, Teachers College, Columbia University, Box 39, 525 West 120th St., New York, NY 10027; or call (212) 678-3904.

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Keep Your Eye On

... free condom giveaways.

Giving high school students free condoms did not cause increased sexual activity, and it even caused a modest increase in condom use, according to a study of 13,000 students in New York City and Chicago.

Researchers at New York University and Hunter College compared the sexual behavior of students in New York City schools, which had given out free condoms, to that of Chicago students, whose schools had not distributed free condoms. They found that sexual activity was similar. Among New York students, 59.7 percent admitted to having sexual activity, compared to 60.1 percent of students in Chicago. But 60.8 percent of New York students said they had used a condom for their most recent sexual experience, compared to 55.5 percent of Chicago students.

The researchers conclude that although there is fear that making free condoms available will increase sexual activity, which is a primary political obstacle to making them available, their study indicates that those fears are unfounded. (*School Board News*, Oct. 14, 1997)

... doctor visits.

In response to teen concerns about visits to the doctor evidenced in a recent study, the authors suggest the following steps pediatricians and other health care providers can take to instill confidence in teens:

- Wash hands and remove instruments from sterile packaging in full view of the patient to allay fears of spreading disease.
- Openly display diplomas to show competence.
- Hold discussions with parents while the teen is present to quell concerns about breaches of confidentiality.
- Explain procedures in simple terms but be sure not to condescend.
- Provide pamphlets or signs explaining why some patients are seen before others, to alleviate fears of discrimination or preferential treatment.

For more information, contact Kenneth R. Ginsburg, M.D., M.S., Ed., at (215) 590-2168.

... hearing impairment testing.

Hearing impairment can delay speech and language skills, which can cause learning problems at school age. However, hearing impairment should be diagnosed early — during the first few months of life if possible, says the Centers for Disease Control and Prevention. Since 1991, the CDC has monitored the prevalence of serious hearing impairment in children ages three to 10 in the Atlanta area. From 1991 to 1993, the CDC identified 413 children with hearing impairment, for an average annual prevalence rate of 1.1 per 1,000 children.

Two-thirds (283) of the hearing-impaired children had sensorineural hearing loss not related to a postnatal cause. Only 13 (8 percent) of those children had their hearing impairment diagnosed during the first year of life, and 81 (47 percent) did not have their impairment diagnosed until they were at least age three. The average age at earliest known diagnosis was 2.9 years. In addition, 50 (29 percent) of a subgroup of 173 children had at least one other disability such as mental retardation or cerebral palsy, and 17 (10 percent) had been very low-birthweight infants.

"Based on the analysis of this report, a substantial proportion of children born with serious bilateral hearing impairment ... were not diagnosed at a sufficiently early age to benefit fully from intervention services to minimize delays in the acquisition of speech and language skills and, possibly, reduce the occurrence of other disabilities associated with hearing impairments," the CDC report concludes.

The agency recommends stronger public health screening of children for hearing impairment, particularly universal newborn hearing programs, which can detect problems early. (*Morbidity and Mortality Weekly Report*, Nov. 14, 1997)

... infant mortality rates.

The federal government's Healthy Start program, intended to reduce infant mortality by half in the nation's poorest communities, may not be working. The $500 million program had little or no impact on infant mortality or the number of low-birthweight babies born in 1994, the first year data have been assessed, according to a report in the Philadelphia Inquirer. Philadelphia is one of the 15 cities the program serves.

A private research firm hired by the government had planned to present the 1994 data at a recent national public health meeting, but federal officials abruptly canceled the presentation, the newspaper reports, because data for the program were incomplete.

Healthy Start began in 1992 and provides prenatal care and some social services to poor women. The program identifies at-risk women and links them to services ranging from pregnancy checkups to well-baby clinics.

The United States has the highest infant mortality rate in the industrialized world, with 8.4 of every 1,000 babies dying before age one. In Japan, the infant mortality rate is 4.4, and in Great Britain it's 6.2. (Reuters)

(Continued on page 9)

Parents
from page 1

glected or have not been discovered, acknowledged and given avenues for expression. The interests of the adult within the parent must be accurately assessed and then met or nurtured by education and social service programs.

What makes it work?

Research has demonstrated that if adults in educational and social service programs initiate and regularly participate in deciding upon and shaping project activities, they will develop a personal sense of ownership of those activities. Research repeatedly shows that adults participate in programs when they recognize that their involvement benefits themselves *as adults*; aids people they want to help; or furthers a cause in which they believe. It is this sense of personal ownership that attracts their involvement in the program. Their participation is sustained when they judge that the program has, in fact, met their expectations and been rewarding to them.

Children and adolescents will also benefit from parents' participation. They have strong developmental needs to make decisions and influence their lives. When parents successfully exercise their will, they will be more likely to permit their children to become self-asserting and autonomous.

Providing decision-making opportunities

In our society, many parents were not regularly permitted to evaluate life options and make decisions when they themselves were children and adolescents, especially those who lived in poverty. Because they were affected by harsh problems and unmet needs, they did not have constructive choice-making opportunities.

Felt ownership, derived from ongoing, broad-based experiences in participatory program decision making, is like a magnet for these parents. It's not at all difficult to understand why. How often have people, especially those who live in poverty, had a legitimate sense of personal control over their lives? How often have they had a chance to participate in making decisions that develop programs important to them as well as to their children and families?

In education and social service programs that serve low-income families, hiring indigenous adult leadership contributes both to parent involvement and a sense of community.

Building community

Since the time of the Puritans, the importance of the community to family life and parenting has been amply demonstrated. Today, the absence of a cohesive, effective community life is a problem that contributes to the isolation, loneliness and lack of support that adults at all income levels feel. Parents often inflict these frustrations on the vulnerable child or adolescent. Helping parents build community should be an important goal of education and social service programs. When program administrators and staff provide a group of parents the opportunity to decide that, as adults, they want the program to help them learn to cook nutritious meals for their families, they take a step toward building community. When a group of parents decides that they want to use a school or center for adult recreation such as a card party or a dance, they take a significant step toward building community.

In education and social service programs that serve low-income families, hiring indigenous adult leadership contributes both to parent involvement and a sense of community. These are people to whom other adults, living in the same neighborhood, often turn for support in times of need.

Indigenous community leaders can best communicate the goals of the program to the community of parents. They are also sensitive to and can effectively communicate parents' problems or concerns to the program's administrators and staff. With a minimum of training, these neighborhood leaders can participate in the ongoing process of learning about the many characteristics of children, adolescents, parents and other family members. These neighborhood program staff members become positive role models for parents.

Program administration

Education and social service programs should require parent representation on administrative policy boards and program committees. Parents should be empowered to ensure that program activities adequately respond to the concerns and interests of the other parents in the program as well as meet the needs of childhood and adolescence. The absence of these empowered parent policy boards and committees at most preschools, child care centers, schools and social service programs significantly inhibits parent involvement.

The attitude of program adminis-

trators and staff toward parent involvement often discourages such involvement. Most directors focus their programmatic efforts solely on education and/or needed social services. Some programs fail to acknowledge that the parent is the primary influence on a child or adolescent. Many administrators lack the knowledge, ability or motivation to involve parents in ways that are meaningful to them. As a result, these programs have no parent policy boards and no parent committees.

A large number of state- and federally funded education and social service programs require parent participation on policy boards and committees. Many of these programs, however, do not involve parents successfully. Although the administrators and staff members at most of these programs may have standard, published program guidelines and procedures for parent involvement, few encourage parents actively and meaningfully to participate on policy boards and program committees.

Some directors fear sharing program control with parents. They think that if parents are given too many opportunities for program oversight, their own administrative power and influence will diminish. Frequently, these directors feel that they may lose control of the program, resulting in an inability to administer the program in a manner that will satisfy themselves or their supervisors. To handle this fear, some directors involve only a limited number of parents or hand-pick those from whom they will receive no administrative threats. Other directors outnumber the parents on these boards with favored professionals and/or staff. Therefore, parents feel their personal and collective power diminish.

Training can address administrators' fears and concerns about losing program control. Current and former education and social service administrators, who have a history of successfully directing programs in which parent groups regularly made decisions, should be selected to provide training.

When those responsible for supervising and administering programs urge, implement and oversee strategies that bring about broad-based parent participation, we will see a marked improvement in the development and well-being of children, parents, families and communities across the United States. ■

Peter Haiman began experimenting with parent involvement program strategies in 1965. He designed and wrote the Parent Involvement Performance Standards for the national Head Start program and, for two decades, was a consultant to Head Start throughout the country. Currently, he is a therapist and child-rearing counselor, and continues to help organizations implement parent involvement efforts.

Suicide

from page 1

young men and doubled for young women.

Following Kevin's death, I became actively involved in the issue of teen suicide, lecturing around the country, appearing on radio and television programs and serving as an adviser to the Gallup organization for their first-ever teen suicide audit.

What I learned was that there are a number of steps we, as parents and members of a community, can take to save some of the young people who end up taking their own lives. I wish I had been aware of these steps in time to help Kevin. Perhaps they can help you.

Parents are often paralyzed by the possibility of suicide, which to them is an unthinkable act, and consequently fail to seek help for their child and themselves. When my wife and I were confronted with an obviously depressed teenager, we were unable to think clearly and take the actions required to save Kevin. My wife and I, frightened and ashamed, didn't talk openly with Kevin about suicide. Nor did we, as husband and wife, talk enough about our fears of it between ourselves. I fully understand now that depression is an illness, not a biblical curse or a moral flaw. Depression has symptoms — just like cancer or heart disease — and, if these symptoms are not treated, the end result can be death. Therefore, parents (and professionals) with depressed children should not be ashamed to seek help.

Parents living with a depressed youngster frequently cope by walking on eggshells. With Kevin, my wife and I were afraid that we'd set him off if we confronted his moodiness. We perceived that a sea of rage was right below the surface of this boy we loved. Yet, rather than deal with it directly, we would walk around it, try to smooth things over and avoid confrontations at all costs.

Instead, my wife and I should have faced our fears and recognized that no parent puts the idea of suicide in a child's mind, nor does that parent make the child commit suicide.

As a first step, we could have simply told Kevin that he appeared to be hurting so badly we were scared that he was thinking about

killing himself.

Parents should not suffer their fear in silence, but instead should tell a trusted friend or member of their family or — best of all — a health care professional. They are facing a life-or-death situation, and the less frightened and isolated they are, the clearer their thinking will be. At the time Kevin was suffering through his depression, my wife and I got lost in our isolation because Kevin was embarrassed about a previous, unsuccessful suicide attempt and didn't want the news to spread. My wife and I were left in a hellish no man's land. We were scared, immobilized and ineffective. Kevin did comply with some minimal rules following his first attempt, but he refused to accept the essential health care services that might have saved his life.

In conjunction with experts in the treatment of potential suicides, parents should develop a plan to address their child's depression, and not settle for anything less than what is essential, be it hospitalization or seeing a social worker or other psychotherapist. Clinical depression is a life-threatening situation, so, if necessary, the paramedics or police should be called. During the final stages of Kevin's illness, he spent six weeks in the psychiatric unit of a hospital. Then one morning, my wife and I were told that the doctor planned to discharge him. We were sure Kevin was still suicidal and told the doctor we were uncomfortable with his decision. But Kevin wanted to come home, and there was nothing we could do about it. A week later, Kevin killed himself. Today, Kevin's mother and I would have had another option. We could have insisted that the court keep Kevin in the hospital, and that the hospital force him to take his antidepressant medication. If we had had the option of a court order, we might still have Kevin.

Clinical depression is a life-threatening situation, so, if necessary, the paramedics or police should be called.

Sometimes a teacher, friend or neighbor will become privy to a disturbing sign manifested by a teenager. Yet, it is only human nature not to want to hear that one's child may be suicidal. But we parents must thank these messengers for their expressions of interest and be sure to check into their observations. I remember that the physician in the emergency room told me that if my son could get his hands on a gun, he'd shoot himself. Even though I knew Kevin was there because of his suicide attempt, I was taken aback by the doctor's words.

Communities can slow the alarming rate of teen suicide by insisting that the health care curriculum in their schools include a powerful message that if any student ever dwells upon the thought that the world would be a better place without him or her, the school caretaker or the parent must seek help immediately. This message can prevent our young people from allowing an insidious depression to enter the danger zone. Students should start hearing this message in elementary school and continue hearing it throughout high school. We wish Kevin had heard that message. Perhaps it would have alerted him to the fatal path he was on.

A family physician can be of enormous help if it's suspected that a teenager is depressed. During a routine physical examination, it is easy enough for the doctor to ask, "Have you thought about or done anything to hurt yourself since your last exam?" A child or adolescent might admit his suicidal ideations or actions to the family doctor before he or she tells anyone else. Recent data indicate that many of the young people we have lost to suicide have visited a health care provider within months of their death.

Suicide hotlines are springing up in cities and towns across America. Kevin died before our community had one, and I believe he would have used a telephone service that promised anonymity and a trained, sympathetic ear. If your community doesn't have a suicide hotline, then professionals and parents need to encourage the local hospital or church or synagogue to start one. If you are fortunate enough to have this service, then display the number by your telephone.

Of course, I do not have the comfort of saying for certain that any of these measures would have saved our Kevin. However, I can say without a doubt that I wish they had been more readily available. ■

Brian Barr and his colleague, Dr. Gabriel Carlson, have made a helpful video called "Demystifying Adolescent Suicide: Addressing the Issue of Stigma and its Impact on Understanding and Healing." It presents a framework for assessing suicidal risk and discusses actions to take if confronted with a potential suicide. For more information, or to order, contact Karen Gaskell, Office of Human Resource Development, New York State Office of Children and Family Services, Twin Towers, 1 Commerce Plaza, Albany, NY 12255, (518) 473-8320. Cost: $10.

W. Brian Barr is associate commissioner of the New York State Office of Children and Family Services. He is a certified social worker and a credentialed alcoholism and drug abuse counselor.

NICHD reorganizes program in child development and behavior

The National Institute for Child Health and Human Development (NICHD) has strengthened its commitment to behavioral and developmental research by combining the Human Learning and Behavior Branch and the Learning Disabilities, Cognitive, and Social Development Branch to form the Child Development and Behavior Branch (CHDB). Reid Lyon, Ph.D., a developmental neuropsychologist, has been named chief of the branch.

The CHDB Branch has primary responsibility for stimulating and supporting research and research training in developmental psychology and cognitive psychology, as well as in the development and support of research on the biobehavioral aspects of development and the behavioral, psychological and biological aspects of health promotion and disease prevention in children from gestation through adolescence. The branch's research and research training portfolios are developed and sustained within the context of four research programs:

1. The research program in cognitive, social and affective development is directed by Sarah L. Friedman, Ph.D. This program focuses on normative research on cognitive, social and affective development, and individual differences in development in these domains in infants, children and adolescents. Interconnections among these domains of psychological development and the ways in which culture, ethnicity and socioeconomic factors affect development are of great interest. Methodological studies pertaining to assessment of the environment and the measurement of psychological constructs as they unfold during development also are of great relevance, as are studies that aim to develop analytical models of development. The program is interested in both small and large research projects and in cultivating the work of beginning scientists as well as established investigators.

2. The research program in learning disabilities, reading development and disorders, and disorders of attention, is directed by Lyon. High priorities within this area are studies that seek to identify the cognitive, linguistic, neurobiological and educational characteristics of normal and atypical development in oral language, reading, written language, mathematics and attention, and studies that identify changes in these domains and correlated neurophysiology as a consequence of behavioral interventions.

   Daniel Berch, Ph.D., a cognitive and experimental psychologist and SRCD research fellow is working with Lyon to develop research initiatives to identify and understand the cognitive underpinnings of mathematics development.

3. The research program in psychobiology and developmental neuroscience develops and supports research to study linkages between human behavior and the developing brain. Of particular interest are studies that develop knowledge about growth patterns of brain and behavior and that shed light on underlying developmental processes and mechanisms at the molecular, cellular and network levels.

   In addition, this program is interested in research that delineates biological and behavioral indices of individual differences predictive of future performance in sensory, motor, linguistic and cognitive domains at different stages of development. Of importance to this program are research initiatives that seek to develop methodologies and tools capable of examining the interface among neurophysiological, behavioral and socio-contextual variables and contexts and that help shape models for understanding the neural bases of complex behaviors.

   The CHDB Branch is actively recruiting a cognitive neuroscientist to lead the NICHD research efforts for this program.

4. The research program in behavioral pediatrics and health promotion research supports research and research training that lead to increased understanding of the psychological, behavioral and biological mechanisms that underlie disease-related risk-taking behaviors (e.g., HIV infection), smoking behavior, obesity, restrictive dieting behavior and, especially, injuries in infants, children and adolescents. This program also develops research initiatives for applied studies and clinical trials to identify promising interventions to prevent disease, obesity, smoking behavior and unintentional injuries.

   The CHDB Branch is actively recruiting a behavioral pediatrician to lead the research efforts in this program.

For more information on these positions, contact Reid Lyon at (301) 496-9849.

Recommended Reading

CHILDHOOD — *C. Jenks. New York: Routledge. 146 pages, $55 (hardcover), $16.95 (softcover), 1997; (800) 634-7064.*

A nice treatment of various conceptions of childhood ("savage," "natural," "social") from a social constructionist perspective, by a wise British sociologist of childhood.

STRENGTHENING THE FAMILY: PROFESSIONAL PARTNERSHIP IN SERVICES FOR YOUNG CHILDREN — *R.N. Roberts, S. Rule and M.S. Innocenti. Baltimore: Paul H. Brookes Publishing. 300 pages, $26.95 (softcover), 1998; (800) 638-3775.*

A very good text for pre-service and in-service training, providing practical advice especially in dealing respectfully with families and various service agencies.

HANDBOOK OF SOLUTION-FOCUSED BRIEF THERAPY — *S.C. Miller, M.A. Hubble and B.L. Duncan (eds.). San Francisco: Jossey-Bass Publishers. 384 pages, $41.95 (hardcover), 1997; (415) 433-1767, ext. 596.*

A great deal of very current information derived from research into clinical practice, with illustrative case examples. Specific guidance is given in the application of methods across treatment settings and with a variety of disorders: domestic violence, chronic and severe mental illness, grief, school problems and other issues.

IS LONG-TERM PSYCHOTHERAPY UNETHICAL? — TOWARD A SOCIAL ETHIC IN AN ERA OF MANAGED CARE — *Carol Shaw Austad. San Francisco: Jossey-Bass Publishers. 384 pages, $36.95 (hardcover), 1998; (415) 433-1767, ext. 596.*

Filled with solid research, clinical examples and interviews, this provocative book makes the case for cost-saving, practical, goal-oriented use of short-term therapy, and challenges therapists to provide behavioral health care that is widely accessible, responsible and ethical.

SUPPORT GROUPS: CURRENT PERSPECTIVES ON THEORY AND PRACTICE — *M.J. Galinsky and J.H. Schopler (Eds.). Binghamton, N.Y.: The Haworth Press. 123 pages, $24.95 (hardcover), 1996; (800) 342-9678.*

Provides framework for understanding and examining supportive group interventions. Provides descriptions of different kinds of support groups and alerts practitioners and educators to issues of planning, implementing and evaluating such services.

DISSOCIATION IN CHILDREN AND ADOLESCENTS: A DEVELOPMENTAL PERSPECTIVE — *F.W. Putnam. New York: Guilford Press. 423 pages, $38.95 (hardcover), 1997; (800) 365-7006.*

Amnesia, intrusive memories, depersonalization, auditory hallucinations, trance-like states and disturbances in identity are all symptoms of pathological dissociation and are among the most devastating effects of childhood maltreatment. This volume introduces an empirical model of dissociation following an important review of the nature and effects of childhood trauma.

Keep Your Eye On
from page 4

... herpes prevalence.

Genital herpes infects about one in five Americans age 12 or older, according to a new report based on a survey by the Centers for Disease Control and Prevention and published in the *New England Journal of Medicine*.

This underscores the need for an effective national effort to stop the spread of herpes and other sexually transmitted diseases.

A relatively benign infection, herpes is not life-threatening and does not progress to a more serious condition. However, it can have a significant physical and emotional impact on people who have the infection.

Herpes sores also can provide a portal of entry for HIV, greatly increasing an infected person's risk of contracting AIDS. Further, in the rare cases where an infected mother transmits herpes to her infant during delivery, the infection can be serious or fatal to the baby.

For more information, contact the National Herpes Hotline at (919) 361-8488. To request a free information packet on herpes or to order other herpes materials, call (800) 230-6039. (Herpes Resource Center of the American Social Health Association.)

"The Shame Response to Rejection"

Herbert E. Thomas, M.D., says, "When this response is significantly intense, it can cause an equally intense psychic trauma, which can be a precursor to violence."

Read about it in next month's *Brown University Child & Adolescent Behavior Letter*.

Guest Commentary

Brief therapy doesn't work for every child

By Sherri Nelson Fitts, Ph.D., and Carol Landau, Ph.D.

The effectiveness of brief therapy is well-established for some psychological conditions. There are several reasons for caution, however, before endorsing the general use of brief therapy. As psychologists who use both brief and longer-term therapies for adolescents and their families, we have learned that the present climate of cost containment can lead to the misuse of data supporting brief treatment.

Therapy for children and adolescents is one of the ways in which brief therapy can be effective. A phobia, for example, is much easier to treat at its inception than after 20 years of entrenched avoidance. But, in general, many psychological problems facing troubled children and adolescents are more complex, and often involve multiple systems. A brief therapy in the life of a depressed or acting-out child living in a chaotic home may have little or no effect, while a longer-term therapy may provide the emotional guidance and support that can have pervasive life-enhancing results. A child who suffers from both learning disabilities and depression may well require more than brief treatment.

A brief therapy in the life of a depressed or acting-out child living in a chaotic home may have little or no effect.

Although many people benefit from one session of psychotherapy and consultation, the hallmark of clinical psychology is to identify which individuals would benefit from specific treatment modalities, long-term or brief. For example, research on the treatment of depression has shown that people who are extremely self-critical and perfectionistic require longer-term therapy. Our belief is that the choice of treatment must be, first and foremost, clinically determined.

In addition, there are many current misperceptions about psychological problems and their treatment. It is incumbent upon us as psychologists and behavioral scientists to provide a coherent understanding of the complex issues involved. While many problems that face individuals are not "severe mental illness," they are chronic, complex and entrenched in many facets of their lives, impairing their functioning in significant, pervasive and sometimes subtle ways.

As any experienced clinician knows, the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)* used for classification of patients by insurance companies tells only a small part of a person's story.

The mandate of managed care companies is to contain health costs. Many forms of brief psychotherapy actually require 10 to 20 sessions, but some managed care companies restrict access beyond eight and, in some cases, to as few as three sessions. This practice has been called "invisible rationing," because the consumer is told that brief therapy is all that is *needed*, rather than all that will be authorized, and is, therefore, unaware of the rationing. Some have suggested that "managed cost" would be a more appropriate term than "managed care."

A 1995 *Consumer Reports* survey of more than 2,500 patients found that they felt more relief with longer psychotherapy. Managed care patients were the most dissatisfied with their psychological care. Although the study had methodological problems, Dr. Martin Seligman, the current president of the American Psychological Association, suggested that this study was unusual in that it demonstrated the effectiveness of psychotherapy from the *patient's* point of view.

We need to be especially mindful when considering the psychological needs of children because they are the political group least able to advocate for themselves. Historically, children have been easy targets for economic cutbacks. Similarly, mothers of young children have very high rates of depressive disorders, but are often underinsured. Both groups are therefore at risk for being politically underrepresented in this era of cost containment.

To be effective, therapy does not necessarily have to be long-term. However, we should not rush to the opposite belief that brief psychotherapy should be the norm. We must be extremely cautious, and protect the best interests of children and their families. ■

Sherri Nelson Fitts, Ph.D., is a clinical psychologist at Women's Health Associates and in independent practice in Providence, R.I. She is also affiliated with Brown University's psychological services. Carol Landau, Ph.D., is a clinical professor of psychiatry and human behavior at Brown University School of Medicine in Providence, R.I. She is also a consulting and clinical psychologist and a member of *The Brown University Child and Adolescent Behavior Letter's* editorial board.

ISSN 0898-2562

The Brown University Child and Adolescent Behavior Letter

Providing the link between behavioral research and your clinical work.

Public Policy

The Adoption and Safe Families Act of 1997 rightly places child safety first

By Richard J. Gelles, Ph.D.

On Nov. 19, 1997, President Clinton signed the Adoption and Safe Families Act of 1997 into law — the most significant change in federal child welfare and child protection policy in nearly 20 years. This was a bipartisan bill crafted by Republicans and Democrats in the House and Senate.

The new law shifts the emphasis of child policy that was set by the Adoption Assistance and Child Welfare Act of 1980 (PL 96-272). The two major child welfare provisions of the 1980 legislation were on permanency planning and "reasonable efforts." Permanency planning was a response to concerns over what child welfare experts had labeled "foster care drift." At the time, in 1980, it was generally believed that too many children were going into foster care each year and too few children were leaving the foster care system. Permanancy planning mandated that states either return children to their birth parents or place them up for adoption, within 18 months of entrance into the child welfare system.

While states are mandated to initiate termination procedures, nothing in the federal law requires the state to present an effective case or solid reasons for the termination.

The second child welfare provision of the legislation involved reasonable efforts. Also aimed at reducing fos-

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Why problems occur for some adopted children

Clinical Issues

The shame response to rejection triggers primitive, physical reactions

By Herbert E. Thomas, M.D.

Our society exists with the understanding that when a person experiences rejection, especially by a significant other, she or he may become upset or angry. This fact is accepted as one of the risks we face in our living together. It's simply one aspect of our humanity. Such a description, however, often fails to account for a very different scenario, one in which rejection causes one to experience a primitive physiological response, a physical response in one's body. I choose to term this the shame response.

When the shame response is sufficiently intense, it can be extremely painful and causes an equally intense psychic trauma. This trauma can be a precursor to violence when the energy associated with the trauma is directed outward. At other times, it can be directed inward, against the self.

The term "rejection" is used in the behavioral sciences much the same way as it's used in everyday conversation. In the context of the phenomenon of a shame response to rejection, however, it's understood

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PS 022215

The Brown University Child and Adolescent Behavior Letter

Editor: Lewis P. Lipsitt, Ph.D.
Professor Emeritus of Psychology, Medical Science, and Human Development at Brown University

Contributing Editors:

Stephen L. Buka, Sc.D., Associate Professor, Department of Maternal and Child Health, Harvard University School of Public Health.

Cynthia Garcia Coll, Ph.D., Professor, Education, Psychology and Pediatrics; Chair of Education Department, Brown University.

Ferdinand Jones, Ph.D., Professor of Psychology, Brown University; formerly director of Brown University Student Counseling.

Dwight B. Heath, Ph.D., Professor Emeritus of Anthropology, Brown University.

Carol Landau, Ph.D., Clinical Professor of Psychiatry and Human Behavior, Brown University; private practice.

Carol Lewis, M.D., Clinical Instructor in Pediatrics, Brown University School of Medicine; private practice.

Theodore R. Sizer, Ph.D., University Professor Emeritus, Brown University; Chairman, Coalition of Essential Schools; former director, Annenberg Institute for School Reform.

Sally Zierler, D.P.H., Associate Professor of Medical Science, Brown University School of Medicine.

Senior Managing Editor: Linda Watts Jackim
Assistant Editor: Steven M. Tobias
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Consulting Editor: Robert B. Whitcomb
Production Coordinator: Helen Ebrahim
Publisher: Fraser A. Lang
V.P. Finance: Paul J. Maloney, CPA
V.P. Marketing: Betty Rawls Lang

The Brown University Child and Adolescent Behavior Letter (ISSN 0898-2562) is published by Manisses Communications Group, Inc., 208 Governor St., Providence, RI 02906; 401/831-6020; Fax: 401/861-6370. Yearly subscription rates are $167 for institutions and $117 for individuals. Periodicals postage at Providence, RI. POSTMASTER: Send address changes to: Manisses Communications Group, Inc., P.O. Box 9758, Providence, RI 02940-9758. ©1998 by Manisses Communications Group, Inc. Member, Newsletter Publishers Association. **The Brown University Child and Adolescent Behavior Letter** reports monthly on work in child development. Our purpose is to provide timely, accurate information by drawing on professional journals, expert opinion and the experience of our editors and guest writers. **The Brown University Child and Adolescent Behavior Letter** does not offer medical, legal or administrative services and we encourage subscribers to seek advice from qualified professionals. **The Brown University Child and Adolescent Behavior Letter** is available in reference systems produced by Information Access Company. For more information, contact Information Access Company, Rights & Permissions Dept., 362 Lakeside Drive, Foster City, CA 94404, or call (800) 227-8431 (U.S. only) or (415) 378-5000. All rights reserved. Reproduction forbidden without the consent of the publisher. Authorization to photocopy articles for internal or personal use or the internal or personal use of specific clients, is granted by Manisses Communications Group provided that the fee of $6.00 per article is paid to the Copyright Clearance Center, 222 Rosewood Drive, Danvers, MA 01923; (508) 750-8400.

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What's New in Research

Case management is not an ideal strategy for raising immunization levels

Case management intervention in the first year of life is an effective—but not cost-effective—strategy for raising immunization levels among high-risk populations, according to a recent study.

To determine the effectiveness of case management in raising immunization levels among high-risk populations, researchers conducted a randomized, controlled trial of 419 inner-city, African-American infants and their famliies. The main outcome measures were the percentage of children with up-to-date immunizations at age one, characteristics associated with improved immunization rates and cost-effectiveness of case management intervention.

A total of 365 newborns were followed up to age one. Overall, the immunization completion for the case management group was 13.2 percent higher than for the control group (63.8 percent vs. 50.6 percent, respectively). In a logistic model, the case management effect was limited to the 25 percent of the sample who reported three or fewer well-child visits; for them, immunization levels increased by 28 percent.

Although intervention for the case management group was not cost-effective at a cost of $12,022 per additional child immunized, costs were lower ($4,546) for the 25 percent of the sample identified retrospectively as having inadequate utilization of preventive health visits.

"Increasing immunization rates among inner-city, African-American children," D. Wood, N. Halfon, C. Donaldson-Sherbourne, et al., *Journal of the American Medical Association* 279:29-34, 1998. For reprints, contact David Wood, M.D., M.P.H., Shriners Hospital, P.O. Box 31356, Tampa, FL 33631-3356.

Are insurers denying appropriate access to care for children?

Recent research indicates that denial of appropriate care is taking place in the U.S. health care system, because medical decision-making is too heavily influenced by insurer decisions regarding access to care.

Researchers examined the medical process affecting access to growth hormone (GH) therapy for childhood short stature by comparing coverage policies of U.S. insurers with the treatment recommendations of U.S. physicians.

The researchers surveyed insurers, health maintenance organizations and Medicaid programs, asking about their coverage decisions for GH therapy. Primary care physicians also were surveyed about decisions regarding referrals to pediatric endocrinologists, and endocrinologists were asked about GH treatment recommendations.

Insurer coverage decisions for GH in specific case scenarios were compared with the recommendations of primary care physicians and pediatric endocrinologists. The researchers found a striking difference between physician recommendations and insurance decisions. For example, although 96 percent of pediatric endocrinologists recommended GH therapy for children with Turner syndrome, insurers covered GH therapy for only 52 percent of those children.

The researchers conclude there is "deep discord" between physician recommendations and insurance coverage decisions.

"Insurance coverage, physician recommendations, and access to emerging treatments," B.S. Finkelstein, J.B. Silvers, U. Marrero, et al., *Journal of the American Medical Association* 279:663-668, 1998. For reprints, contact Beth S. Finkelstein, Ph.D., Department of Pediatrics, Case Western Reserve University, 2109 Adelbert Road, Cleveland, OH 44106.

Beware first-time use of smokeless tobacco

A study of smokeless tobacco use among youth indicates that roughly one-third of those who try smokeless tobacco end up becoming regular users.

Among 7,830 11- to 19-year-olds, 12.7 percent (20.9 percent of males) first tried smokeless tobacco during the four-year period studied, and 4 percent (8 percent of males) became regular users. Each year, about 824,000 youths experimented with smokeless tobacco and about 304,000 became regular users. Cumulative incidence was highest for male non-Hispanic white youths. Predictors of regular use included age, geographic location, cigarette smoking, participation in organized sports and friends' perceived approval or indifference to smokeless tobacco use.

Data were obtained from the 1989 Teenage Attitudes and Practices Survey and a 1993 follow-up study.

"Incidence and predictors of smokeless tobacco use among U.S. youth," S.L. Tomar, G.A. Giovino. *American Journal of Public Health* 88:20-26, 1998. For reprints, contact Scott L. Tomar, D.M.D., Dr.P.H., Department of Dental Public Health and Hygiene, School of Dentistry, University of California, San Francisco, CA 94143-0430.

Does preterm monitoring reduce prematurity risk?

Women who have daily contact with a nurse, whether it includes home monitoring of uterine activity or not, do not have better pregnancy outcomes than women who merely have weekly nurse contacts, according to new research.

Investigators randomly assigned 2,422 pregnant women with known risk factors for preterm labor to receive education and one of the following interventions: weekly contact with a nurse; daily contact with a nurse; or daily contact with a nurse and home monitoring of uterine activity.

The primary endpoint of the study was the incidence of birth at less than 35 weeks' gestation. Secondary endpoints included whether cervical dilation was present when preterm labor was diagnosed, and the newborn's birth weight.

No significant differences were found among women who gave birth at less than 35 weeks' gestation (14 percent in the weekly contact group, 13 percent in the daily contact group and 14 percent in the home monitoring group). There also were no significant differences found in the average amount of cervical dilation at the time preterm labor was diagnosed, or in neonatal outcomes such as birth weights of less than 1,500 grams. Daily nurse visits did increase the average number of unscheduled visits to obstetricians, however, with 1.2 visits in the weekly contact group, 1.8 in the daily contact group and 2.3 in the home monitoring group. Daily nurse contact also increased the likelihood that women would receive prophylactic tocolytic drugs to delay labor.

"Monitoring women at risk for preterm labor," D.C. Dyson, K.H. Danbe, J.A. Bamber, et al., *New England Journal of Medicine* 338:15-19, 1998. For reprints, contact Donald C. Dyson, M.D., Department of Obstetrics and Gynecology, Kaiser Permanente Medical Center, 900 Kiely Blvd., Building J, Suite 2, Santa Clara, CA 95051-5386.

Resources

Music for Little People releases a collection of folk music

Music for Little People, an award-winning children's music label, has created a new collection of 15 classic songs for children that revolve around folk music, circle songs and clapping games. Called "Shakin' a Tailfeather," the collection is sung by renowned blues master Taj Mahal. The song collection was recently nominated for a Grammy award for Best Children's Recording. For more information, call (800) 346-4445 and ask for Annie Braak at extension 116 or Anna Cherekovsky at extension 115. The e-mail address is musicforlittlepeople@mflp.com.

Poison prevention brochure is available from AAP

The American Academy of Pediatrics has a brochure on protecting children from accidental poisoning titled "Protect Your Child from Poison: Guidelines for Parents." It contains information on poison-proofing the home and on treating children who have swallowed poison. The brochures are available for $29.95 per 100, plus shipping and handling. To order, contact the American Academy of Pediatrics, P.O. Box 747, Elk Grove Village, IL 60009-0747; phone (847) 228-5005.

Keep Your Eye On

... MRI scans.

Researchers at McLean Hospital in Belmont, Mass., have discovered a new, high-tech weapon in the war on drugs: functional magnetic resonance imaging (MRI). The brain scan provides safe and rapid images of brain activity, and researchers are using it to investigate a new area of drug abuse research — the effects of cocaine craving on the brain. Perry Renshaw, M.D., Ph.D., director of the hospital's brain imaging center, and colleagues found that use of cocaine activated two specific parts of the brain, the anterior cingulate and the dorsolateral prefrontal cortex, that are involved in human emotional response. Those findings are consistent with previous results using an older technology of brain scanning, positron emission tomography (PET). More research is planned to study the neurobiological basis of cocaine craving, which may lead to developing new, more targeted methods of treating drug addiction. (McLean Hospital)

... children and depression.

The National Institute of Mental Health (NIMH) is supporting the opening of three child psychopharmacology centers to conduct medication studies on children with depression and anxiety disorders. The three centers will be Columbia University's College of Physicians and Surgeons in New York City, Johns Hopkins Medical Institutes in Baltimore and the University of Pittsburgh. Despite very few studies on antidepressants in children, 200,000 prescriptions for fluoxetine (Prozac) and 300,000 prescriptions for sertraline (Zoloft) were filled for children ages five to 10 in 1994. In that same year, 150,000 prescriptions for those two drugs were filled for adolescents. (Los Angeles Times)

... an antidote to angel dust.

Scientists have created an antidote to angel dust, or PCP, a powerfully addictive drug that can make users lash out violently and think they are invincible. In an animal study at the University of Arkansas in Little Rock, researchers created an antibody fragment that counteracts the effects of an overdose of PCP. Within minutes, the effects of the drug are completely gone. The antibody could become a cure for an overdose of PCP. Similar antidotes also could be created for such other street drugs as methamphetamines using the antibody technology. (United Press International)

... dyslexia and the brain.

A new study supports the theory that dyslexia may be caused by a subtle vision impairment. In a small group of dyslexics studied at Stanford University, researchers found that the level of activity in the visual cortex, the portion of the brain devoted to processing visual signals, appears to predict the speed at which dyslexics can read. David J. Heeger, Ph.D., assistant professor of psychology at Stanford, says, "We found compelling evidence that there is a visual deficit associated with dyslexia, but at this time, we don't know for certain if the deficit causes dyslexia or if it's just a marker for it." The researchers used magnetic resonance imaging (MRI) and looked specifically at magnocellular neurons, or the "M" cells, to determine visual and brain processing. It has been proposed that a deficiency in the M cells could cause dyslexia. Although the new results are too preliminary to affect actual treatment of dyslexia at this time, they do suggest that more research is warranted. (Stanford University)

... at-risk infants.

Reducing a newborn's brain temperature may have a long-lasting neuroprotective effect in babies who have difficulty establishing respiration at delivery. Pediatricians from University College in London and Ulleval University in Oslo, Norway, reviewed the practice of using hypothermia treatment on at-risk newborns, which is often called "neural rescue therapy." In one study the pediatricians evaluated, 65 infants who were born unresponsive were immediately treated with a specially designed cold water bath to lower their body temperature. Of the 65 infants, 52 survived and none showed any signs of cerebral palsy. The pediatricians hypothesize that the rapid cooling of the babies allows for their prolonged survival because their need for oxygen is reduced. The treatment is considered promising, and could be studied in the future as a way to prevent perinatal brain damage. (PR Newswire)

... challenges of adolescent girls.

The head of the nation's largest group of obstetricians/gynecologists is warning that adolescent girls are facing increasingly difficult mental and physical stress. "Certain cultural and behavioral trends, coupled with a teenager's belief that 'it won't happen to me,' are creating some potential land mines in this generation's road to good health," says Luella Klein, M.D., director of the American College of Obstetricians and Gynecologists' (ACOG's) Division of Women's Health Issues. Two of the major problems Klein cited were earlier sexual activity (66 percent of girls have had sex by the

Being adopted may not pose a problem until adolescence

Not all adopted children have psychological problems. When problems do occur, it usually reflects the child's stage in development. Children may know by the age of five or six that they are adopted, but they do not understand fully what being adopted means until early adolescence.

When adopted children are young, around five or six years old, they are often told they are special — a gift to their parents. Usually, they believe this to the point of seeing themselves as more loved and better off than their peers.

Around the age of six or seven, many adopted children show separation anxiety. They cling to their parents, not wanting to leave home or go to school. At eight or nine, they often turn their anxiety outward, throwing tantrums or becoming very aggressive.

As the children enter the early years of adolescence, they begin to face identity questions and may start asking about who they are and where they came from. When they have trouble getting answers to these questions, they fully appreciate the emotional, intellectual and social impact of being adopted.

Disrupted attachments and poor bonding may occur. The psychological effects can be troubling, especially when they show up after the adoptive parents have grown to believe all the issues of the adoption have been resolved.

Reasons for problems

Psychologists give three possible explanations for psychological problems in adopted children:

1. Grief. Adopted children struggle with the loss of their birth parents, siblings and cultural/religious heritage. Their problems are expressions of this loss.
2. Inadequate coping mechanisms of the adopting family. Early adolescents struggle with the emotional and social impact of being adopted after their parents have come to believe the children were content. Many such families deal with renewed identity questions.
3. Stigma. Adopted children face emotional risks from the stigma that society places on them, intentionally or not.

Even among well-adjusted adopted children, certain issues resonate with powerful

Continued, over ...

consequences. Listed here are some behaviors that commonly occur in adopted children:

- Children will fantasize about their birth parents. This is an attempt to disconnect from their adoptive parents, which is a normal process for all children.
- Children aware of adoption sense that they have no control. They will wonder why and how they ended up with their adoptive parents. At the same time, they may attempt to take control of their lives by stealing and hoarding, for example.
- Many adopted children develop a damaged self-image, are oversensitive to criticism and feel a sense of isolation.
- Children may believe that they come from a "bad seed," or they may behave poorly as a way of identifying with a "bad" birth parent.
- Children will wonder whether they have biological siblings.

All of these stages and questions require adoptive parents to walk the fine line between openness and concealment of negative elements of their child's past. In general, strategies that emphasize empathy, patience and getting professional help when indicated will keep most of these issues from developing into problems.

Source: Brian Hayden, Ph.D., is an associate professor in the department of psychology at Brown University.

The Brown University Child and Adolescent Behavior Letter

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12th grade), and society's current cult of thinness, which leaves girls more vulnerable to low self-esteem and risky behavior such as smoking. ACOG recommends that teenage girls have their first OB/GYN visit when they are 13 to 15 years old, and that physicians be better educated on discussing risky behavior with teens. (American College of Obstetricians and Gynecologists)

... child health services research.

Child health services research should be a separate entity from adult research, according to a report from the Agency for Health Care Policy and Research (AHCPR). According to Christopher Forrest, M.D., Ph.D., of the Johns Hopkins School of Public Health, and colleagues, ignoring or minimizing attention to child health services research is "both shortsighted and ultimately costly for families and the entire nation."

Why? Because children's cognitive, emotional and social development are constantly changing, outcome measures must be sensitive to those changes. In addition, alterations in the rate of development can be important outcomes as well, and should be part of studies on children's quality of health. Fewer than 5 percent of children are affected with conditions such as diabetes that are usually addressed by outcomes research in adults, even though one-third of medically underserved Americans are younger than 18 years of age.

AHCPR proposes these strategies for increasing the quality of child health services research:

- Expand the disease orientation of health services research to include a focus on child health development.
- Establish child-sensitive standards for setting research priorities.
- Increase the size and capacity of the child health services research workforce.
- Develop appropriate laboratories to study child health care.
- Improve coordination of research funding across the federal government, foundations and the private sector.
- Enhance the research function of health care delivery in the private sector. (Agency for Health Care Policy and Research)

Adoption law
from page 1

ter care drift and inappropriate out-of-home placement, the policy of "reasonable efforts" was stated in a brief but important section of the 1980 legislation:

"... in each case, reasonable efforts will be made (A) prior to the placement of a child in foster care, to prevent or eliminate the need for removal of a child from his home, and (B) to make it possible for the child to return to his home."

The 1997 Adoption and Safe Families Act attempts to shift the emphasis of the 1980 act, explicitly stating that the "paramount concern" of all child protection efforts must be the health and safety of children, even if this means overriding the "reasonable efforts" requirement in some cases. Reasonable efforts are specifically not required when a court determines that a parent has subjected the child to aggravated circumstance, the parent has attempted or committed voluntary manslaughter or murder and/or the parent has committed felony assault that severely injured the child.

A second important change is that states may concurrently make reasonable efforts to place a child for adoption or with a legal guardian and make reasonable efforts to preserve and reunify families.

A third change, one designed to enhance permanency and safety for children, is the provision that states *must initiate* a petition to terminate parental rights and move toward adoption when one of the following is true:

- A child has been in foster care for 15 of the most recent 22 months.
- A court has determined a child to be an abandoned infant.
- The parent has attempted to murder one of his or her children, or has committed voluntary manslaughter of one of his or her children, or has committed a felony assault that resulted in se-

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rious bodily injury to one of his or her children.

Law establishes time lines and incentives

Among the other important provisions of the law are the establishment of time lines for terminations of parental rights, financial incentives to the states to increase adoptions ($4,000 for every child adopted over the state's base number of foster care adoptions; $2,000 for every special-needs adoption) and requiring a permanency hearing to be held 12 months, rather than 18 months, after a child comes into state care.

As important as the new federal law is, it does not guarantee or ensure that children's health and safety will be improved.

Four weeks after I witnessed the president sign the Adoption and Safe Families Act of 1997, I found myself four miles from the White House in a Maryland courtroom testifying in an adoption proceeding. The case seemed clear-cut, at least to me. A woman who had killed one of her four children (and who had committed credit card fraud) was seeking to block the adoption of one of her surviving children — a two-year-old boy. The biological mother had placed her son with an acquaintance because she was going back to jail to serve her sentence for the killing of her child. The acquaintance had fallen in love with the two-year-old and filed an adoption petition. The biological mother had a long list of problems, including the homicide and the felony credit card convictions. Were the mother to regain custody, the two-year-old would have to live with her in a halfway house. The acquaintance had done an excellent job of raising the baby for nearly two years — 18 months longer than the biological mother had raised the child.

The judge, weighing all the data and expert opinion, decided that children do best when raised by their biological families, and ordered the two-year-old returned to his mother in 60 days.

How well will states implement the law?

While the new law requires states to initiate petitions to terminate parental rights and to place the health and safety of children as the paramount concern, the decision to terminate parental rights remains with the courts.

Since the enactment of the law, some state departments of child welfare have voiced concerns that the time lines are too short, saying they need more time to help parents change. States also have voiced concerns that they have insufficient resources and personnel to make efforts to assist parents who have maltreated their children. While states are mandated to initiate termination procedures, nothing in the federal law requires the state to present an effective case or solid reasons for the termination.

As important as the law is in signaling a concern for child health and safety, the devil is still in the details. The well-intended 1980 law failed to adequately protect children because of how it was implemented — in too many cases, state child welfare agencies made "every possible effort" to keep families together. It remains to be seen how states implement the new law and whether states can keep maltreated children safe and out of harm's way. ■

Richard J. Gelles is director of the Center for the Study and Prevention of Intimate Violence at the University of Rhode Island. He is the author of several books on intimate and interpersonal violence, including *The Book of David* (New York: Basic Books, 1996; 800-331-3761).

Shame

from page 1

as the transformation of a person from a subject into an object. In other words, to reject someone is to objectify that person.

Several factors determine the intensity of a rejection. These include:

- The significance to the person rejected of the one who rejects.
- The significance to the person rejected of those who witness the rejection.
- The rejected person's vulnerability to experiencing rejection.
- Whether what is rejected is an aspect of one's self or of one's whole self.
- The degree of surprise associated with the rejection.
- The correlation of the rejection's intensity to the intensity of the shame response.

The physiological response

The shame response to the experience of rejection is a primitive physiological one. The more intense it is, the more painful it is. The pain experienced can range from a slight pain in one's chest, often in the region of one's heart, to a pain so intense that one feels one's chest will explode. This is just one example of a shame response; they can occur elsewhere in the body.

The intensity of the shame response determines what follows. One may become angry and direct that anger outward. In such cases, the anger may be manifested as violence toward others. When the anger is directed inward, it may lead to a vicious cycle of self-hatred, in which the person becomes isolated

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and withdrawn in order to avoid the possibility of further rejection. The trauma associated with the pain of an intense shame response can lead to all the phenomena we associate with a post-traumatic stress disorder.

There is evidence to suggest that the pain associated with the shame response is located in a particular region of the brain, possibly in the cingulate gyrus or nearby. This region may act as the focus for the phenomenon of "kindling." Simply stated, a slight rejection may release the energy associated with previous, painful experiences of rejection. This can be seen in the youngster who becomes enraged following what appears to the onlooker to be a minimal rejection.

Ancient methods of coping

Historically, societies have developed various means of protecting individuals from a full experience of rejection. In ancient Greece, there was a belief that, at times, one's mind was possessed by a god descending from Mount Olympus. By attributing a personal transgression to a higher authority, one could avoid the social consequences, including rejection, that would otherwise flow naturally from the act.

A century ago in Japan, patterns of acceptable behavior were determined by a rigid and all-pervasive social code. Strict adherence to them allowed the individual to avoid rejection by others. When a man or woman did cross the accepted bounds of social behavior, however, the personal consequences were devastating.

In the United States, social contracts that would prevent random acts of rejection have been few and far between. As a result, the incidence of individuals experiencing intense shame responses, ones that are very painful, has been exceedingly high. These individuals, especially children, are often unable to find or, when found, accept the care they so badly need. In part, this may be due to their rejecting in themselves that which was rejected by a significant other. It may also be due to a general lack of understanding on the part of therapists, who themselves are often scarred by experiences of shame responses to rejection as well as the formidable defenses against re-experiencing the pain.

Avoiding future pain

Because the wounds that result from the pain of rejection are especially difficult to heal, those who have experienced intense rejection are often dominated by a desire to avoid further acts of rejection. By consciously and deliberately ensuring that our posture toward others is one of acceptance and not rejection, we can help protect those at risk from repeated painful experiences. Only by understanding how pervasive acts of rejection are in our society, and how many people are seriously wounded by them, can we ever hope to diminish the level of violence we now see.

The child who goes into paroxysms of rage at the least rejection cannot simply be written off as difficult. Rather, she or he may have reached a point of saturation wherein further experiences of rejection are simply unbearable.

Children live in a world that is populated by highly significant others. Adults have enormous power to behave in ways that cause children to experience rejection and, thus, intense physical pain. When a worker in a youth development center, a teacher in a classroom or a parent speaks to a child in ways that communicate acceptance and not rejection, they are, in effect, protecting the youngster from experiencing more pain. The healing power of this implied code of conduct is an extraordinary resource for anyone with authority in a hierarchical system.

We must remember always that those most vulnerable to rejection and the physical pain that accompanies it are children. Once experienced, this pain is stored away. The child who goes into paroxysms of rage at the least rejection cannot simply be written off as difficult. Rather, she or he may have reached a point of saturation wherein further experiences of rejection are simply unbearable.

In this light, we can perhaps better understand the experience of young Pip in Charles Dickens' *Great Expectations*:

"She came back, with some bread and meat and a little mug of beer. She put the mug down on the stones of the yard, and gave me the bread and meat without looking at me, as insolently as if I were a dog in disgrace. I was so humiliated, hurt, spurned, offended, angry, sorry — I cannot hit upon the right name for the smart — God knows what its name was — that tears started to my eyes. The moment they sprang there, the girl looked at me with a quick delight in having been the cause of them.

"But, when she was gone, I looked about for a place to hide my face in ... As I cried, I kicked the wall, and took a hard twist of my hair; so bitter were my feelings, and so sharp was the smart without a name, that needed counteraction." ■

Herbert E. Thomas is medical director for the forensic programming of The Center for Addiction Services at St. Francis Medical Center, Pittsburgh.

Commentary

Development and destiny derailed

Seven months ago, the life and death of Princess Di culminated in a memorable final day of tribute throughout the world. The question asked by many distraught mourners was, "Why her?"

While a desperate emotional search for answers arose among Diana's worldwide admirers, a cerebral inquiry was evident among TV commentators, newspaper and magazine writers and social historians. Lamenting the loss, they wondered nonetheless about the enormity of the raw public cry over her death. What, they asked, has set off this massive adoration of one who was known personally by so few of the millions of mourners? Even psychotherapists were astonished at the frequency with which "issues" about Diana arose in the dialogue of the treatment room.

George Will (*Newsweek*, Sept. 15, 1997), called the week of mourning "sheer fakery." His words were not simply of one whose curiosity had been piqued. He complained: "cultural froth," "a bull market in bathos," "self-deception and autointoxication," "mass parasitism," "catharsis of emotional exhibitionism" and "people ... clutching at the flying coattails of history."

The Princess Diana phenomenon does cry for answers. The massive outpouring of grief, the *stunning* of the populace, the screaming quietude of crowds inside and outside the Abbey at her funeral were more impressive than the world's reactions to the deaths of Winston Churchill, Franklin Roosevelt, Mahatma Gandhi and Mother Teresa.

Where do we have to go to find the harp with which Diana so beautifully struck the people's chords? Surely she wanted to be the People's Princess, but we did not know that she had succeeded until she died. Moreover, that status was bestowed on her by some only in a dramatic turnabout from a position of bemusement and bewilderment. Many of these "reformed admirers" previously expressed outright hostility over her having shaken and perhaps destroyed traditional images and respect for the royal dynasty.

What touched people so deeply? The devotion was surely not to Diana alone. One doesn't make fast friends with others that quickly. No, the tragedy mourned was our own: What touched us most deeply was the derailment of a developing person. Diana had captured our attention with her fairy-tale life and her candid revelations about her private anguish. It was not so much her reports of the downside of royal life, although to be sure there was enough voyeurism focused on that. More likely, it was her confession of personal problems, her love for and protection of her children and her avid pursuit of pleasure under unique conditions of both privilege and oppression.

Diana's attention to the poor and to people with AIDS, and her capacity for getting physically close to people less fortunate, did not go unnoticed by the millions who feel unfulfilled, or abandoned.

Diana had engaged in and disclosed infidelity, depression, divorce and suicide attempts. She cried publicly for privacy, she pleaded for help and she desperately sought relief. These are all universal spheres of understanding.

The revelation of secret conversations called forth the memories of betrayal that most of us have suffered. Just about every adjective that news writers could use, from nurturant to self-destructive to lonely, has been drawn on to describe the "Princess Di personality" that no longer is, because she was, as one TV commentator said, the face that launched a thousand fantasies.

But The Face was more than a face. Di was a vulnerable person, like most of us, but resilient, like most of us wish to be. She confessed her fragility, often and in public. She gave the impression that she wasn't yet where she was going to be. That is what most humans like to think about themselves — that we are moving on and will overcome. Princess Diana was, in an important sense, Everyone.

Most thinking people try to "make sense" of their own life events and the personal histories of others, in terms of what went before, and the contexts in which the life has been lived. Understanding the causes of our behavior is a legitimate, fascinating pursuit. This is not precise science, even in the hands of experts: Unforeseen conditions intervene, and often prevail. In our attempts to understand the catastrophic fate of an individual, we are often left wondering why.

Diana's life was unfulfilled, and the unfulfilled life is Everyone's worst nightmare. Diana lived her short life with conflict and sadness, sometimes with shame and regret. She was trying to overcome: Long live human striving, empathy and hope.

Lewis P. Lipsitt

ISSN 0898-2562

The Brown University Child and Adolescent Behavior Letter

Providing the link between behavioral research and your clinical work.

Perspective

Explaining the unthinkable: The Jonesboro tragedy

By Richard J. Gelles, Ph.D.

When the gunfire in the Jonesboro, Ark., schoolyard stopped, the media headed out in two different directions. One group headed for Jonesboro to answer the question, "What happened?" The other group looked to answer the question, "Why?" Pagers, cell phones and voice mail of professionals who study child and youth violence sprang to life.

My one consistent finding is that these children, wherever they live and whatever weapon they use, all lack social capital.

The rarity of a mass slaying at a school and the allegation that the offenders were merely 11 and 13 years of age generated non-stop media coverage for more than a week. The usual experts were rounded up and pressed for explanations, even before any scraps of information were available about the two young perpetrators.

The rarity of the event and the young age of the offenders make this unthinkable act nearly unexplainable. The media-wise experts, and in some cases, experts who were merely self-proclaimed and available, offered up sound bites about guns, Southern gun culture, the decay of the American family, epidemics of youth violence and "super predators." But the glib sound bites masked the reality that when something as uncommon as the Jonesboro mass murder occurs, it not only defies a simple explanation, it nearly defies explanation at all.

On average, about 100 homicides are committed by children under 14 each year. Since there are nearly 58 mil-

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Inside This Issue

Robert Perloff, past president of the American Psychological Association, remembers Dr. Benjamin Spock.
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Childhood obesity predicts adult obesity independent of parent obesity.
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Environmental tobacco smoke is associated with middle-ear disease in preschoolers.
See page 4

Commentary: Did the Jonesboro tragedy happen because of social context, or was it the boys' personal characteristics, like failure of attachment to others?
See page 8

This month's client handout: **Help build your child's self-esteem**

Early Intervention

Emotional, social skills eliminate need for 'wars' on behavioral misadventures

By Daniel Goleman, Ph.D.

Over the last decade or so "wars" have been proclaimed, in turn, on teen pregnancy, dropping out, drugs and, most recently, violence. The trouble with such campaigns is that they come too late, after the targeted problem has reached epidemic proportions and taken firm root in the lives of the young. They are crisis intervention, the equivalent of solving a problem by sending an ambulance to the rescue rather than giving an inoculation that would ward off the disease in the first place. Instead of more such "wars," what we need is to follow the logic of prevention, offering our children the skills for facing life that will increase their chances of avoiding any and all of the above fates.

To focus on the place of emotional and social deficits is not to deny the role of other risk factors, such as growing up in a fragmented, abusive or chaotic family, or in an impoverished, crime- and drug-ridden neighborhood. Poverty itself delivers emotional blows to children. Poorer children at age five are already more fearful, anxious and sad

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Editor: Lewis P. Lipsitt, Ph.D.
Professor Emeritus of Psychology, Medical Science, and Human Development at Brown University

Contributing Editors:

Stephen L. Buka, Sc.D., Associate Professor, Department of Maternal and Child Health, Harvard University School of Public Health

Cynthia Garcia Coll, Ph.D., Professor, Education, Psychology and Pediatrics; Chair of Education Department, Brown University

Ferdinand Jones, Ph.D., Professor of Psychology, Brown University; formerly director of Brown University Student Counseling

Dwight B. Heath, Ph.D., Professor Emeritus of Anthropology, Brown University

Carol Landau, Ph.D., Clinical Professor of Psychiatry and Human Behavior, Brown University; private practice

Carol Lewis, M.D., Clinical Instructor in Pediatrics, Brown University School of Medicine; private practice

Theodore R. Sizer, Ph.D., University Professor Emeritus, Brown University; Chairman, Coalition of Essential Schools; former director, Annenberg Institute for School Reform

Sally Zierler, D.P.H., Associate Professor of Medical Science, Brown University School of Medicine

Senior Managing Editor: Linda Watts Jackim
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The Brown University Child and Adolescent Behavior Letter (ISSN 0898-2562) is published by Manisses Communications Group, Inc., 208 Governor St., Providence, RI 02906. 401/831-6020; Fax 401/861-6370. Yearly subscription rates are $167 for institutions and $117 for individuals. Periodicals postage at Providence, RI. POSTMASTER: Send address changes to: Manisses Communications Group, Inc., P.O. Box 9758, Providence, RI 02940-9758. ©1998 by Manisses Communications Group, Inc. Member: Newsletter Publishers Association. **The Brown University Child and Adolescent Behavior Letter** reports monthly on work in child development. Our purpose is to provide timely, accurate information by drawing on professional journals, expert opinion and the experience of our editors and guest writers. **The Brown University Child and Adolescent Behavior Letter** does not offer medical, legal or administrative services and we encourage subscribers to seek advice from qualified professionals. **The Brown University Child and Adolescent Behavior Letter** is available in reference systems produced by Information Access Company. For more information, contact Information Access Company, Rights & Permissions Dept., 362 Lakeside Drive, Foster City, CA 94404, or call (800) 227-8431 (U.S. only) or (415) 378-5000. All rights reserved. Reproduction forbidden without the consent of the publisher. Authorization to photocopy articles for internal or personal use or the internal or personal use of specific clients, is granted by Manisses Communications Group provided that the fee of $6.00 per article is paid to the Copyright Clearance Center, 222 Rosewood Drive, Danvers, MA 01923, (508) 750-8400.

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Printed in USA

Keep Your Eye On

... anxiety-reducing premedication.

A new study from Yale-New Haven Children's Hospital indicates that premedicating children with the short-acting sedative midazolam (Versed) prior to surgery significantly reduced their anxiety when separated from their parents to enter the operating room.

Of 85 children ages one to six who received general anesthesia and surgery, 90 percent of those premedicated in the preoperative holding area before surgery were significantly less anxious than children who received parental comforting only. Premedicated children also were more likely to comply with placement of the anesthesia mask compared with the control group.

The children received midazolam 15 minutes prior to entering the operating room. Midazolam was approved last year as a sedative for use in newborns, infants and children in critical care settings.

Zeev N. Kain, M.D., director of pediatric anesthesiology at Yale University School of Medicine in New Haven, Conn., says other measures also may help alleviate children's anxieties prior to surgery, such as explaining the procedure in simple, clear terms and having the child go on a hospital preadmission tour. (Yale-New Haven Hospital)

... children's services in 1999.

Although 1999 is being touted as the first year Congress has adopted a balanced budget in 30 years, the proposed budget still has some shortfalls for children's services in areas such as special education and social service block grants.

The total proposed budget for the Department of Health and Human Services is $380.6 billion, a 6 percent increase over the 1998 budget. Although programs such as Head Start and the Foster Care and Adoption Assistance entitlement program will receive budget increases, the Social Services Block Grant program is slated to lose $390 million compared to last year's budget. The program allows states to provide supplemental services to foster care and adoption services, substance abuse treatment and prevention, child care, employment services and services for the disabled.

In addition, the proposed 1999 budget would increase spending for the Individuals with Disabilities Education Act (IDEA) by $35 million for a total of $4.6 billion, although advocates of the program say much more of an increase is needed. Education Secretary Richard Riley defended the budget, saying it has increased by 64 percent in the last three years. But Joseph Ballard, director of public policy for the Council for Exceptional Children, a professional association for special educators, says the $35 million budget for 1999 "is barely enough to sustain an existing educational program, much less enact a program that involved such wide-ranging reforms as IDEA '97." (*Children's Services Report*, Feb. 16, 1998)

BEST COPY AVAILABLE

Help to build your child's self-esteem

How can parents and professionals help ensure that children will be responsible for their education, leisure time use and overall well-being? Dr. Robert B. Brooks, assistant professor of psychology at Harvard Medical School, believes that adults can help by fostering children's self-esteem. And he says that children will have greater self-esteem if they feel a sense of ownership and responsibility for their experiences.

Many children don't have that feeling. "They think in terms of 'I have to go there. I have to do this, I have to do homework.'" It is important to their success and self-esteem that they feel they have a personal, vested interest in their activities. Brooks offers three tips for fostering self-esteem:

Freedom to make mistakes

One roadblock to feeling vested is not having the freedom to make mistakes. Brooks wishes that adults would admit that they make mistakes and talk about the nature of making mistakes — the fear, the intimidation and what it does to people. He says it is a fear that interferes with emotional development and with trying new things.

Brooks recommends that adults ask children what they think are appropriate actions to take when people make a mistake. "Ask them, 'Should we insult them and make fun of them?'" Chances are children will answer no. An open discussion of their fears can serve to teach children that mistakes are normal and are part of learning.

Children with good self-esteem seem to believe that mistakes are experiences to learn from rather than be defeated by, Brooks notes. Children who do not perceive mistakes that way feel helpless, he says. Thus, their mistakes really do turn out badly. "They become class clowns, class bullies, they retreat, they use drugs, they become self-destructive … It's learned helplessness — that feeling that regardless of what I do, I cannot bring about positive change."

Making a contribution

Self-esteem stems from feeling valued. "Many children and adolescents are drowning in an ocean of inadequacy. They feel they are not competent," Brooks says. "I believe every child in the world has at least one small island of competency, one area which can serve as a source of pride." Finding that island of competency and offering ways for children to contribute can help them build self-esteem. "The feeling that you are contributing is very powerful," he says.

Brooks says he once treated a little boy who sat in the bushes every day and refused to go into the school. The boy said he liked bushes better than he liked school. Says Brooks, "I had a choice of either getting into a debate about the relative merits of bushes vs. school, or I could find his island of competence, so I asked what he enjoyed doing."

The boy said that he really liked caring for his pet dog. Soon the school

principal invited the child to care for the school's pet rabbit. "This kid who thought he had nothing to contribute wrote a manual on taking care of pets," says Brooks. "By the end of the school year this kid had lectured to every class in the school, and he told me the bushes were not exciting any more."

Giving a choice

A third strategy for fostering self-esteem is giving choices. "Anything can be a choice," Brooks points out. "Anything can be a decision. I read one article that said if you give kids a choice of writing in blue ink or black ink they'll write more than if you just tell them to write."

Children surely will not develop a sense of ownership and responsibility if other people always decide what they will do and when and how they'll do it. Real choices, appropriate to children's ages, also permit them to experiment, make mistakes and learn in nonthreatening situations.

The Brown University **Child and Adolescent Behavior Letter**

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PLACE YOUR BUSINESS CARD HERE BEFORE PHOTOCOPYING

... fetal exposure to cocaine.

Ongoing studies suggest that cocaine exposure in utero may not be as dismal a prospect for babies as has been projected. In a recent meeting sponsored by the New York Academy of Sciences, experts said that the extent of cognitive and behavioral impairment in children born to women who used cocaine while pregnant depends in large part on the environment into which the children are born.

Effects tend to be more behavioral than cognitive, the researchers reported, with behavioral manifestations of prenatal cocaine exposure including restlessness, fussiness, irritability, distractibility and impulsivity.

In a National Institutes of Health study of 1,400 children up to age seven, it appears that children growing up in a nurturing environment — such as those adopted by families not using drugs or those born to mothers who receive drug treatment and parent training — have a chance to overcome risk factors associated with prenatal cocaine exposure.

But children growing up surrounded by drug use, in poverty and with poor parenting appear to have more behavioral problems, the researchers reported.

In another small study of 200 children who have been followed since 1989, researchers from the Albert Einstein Medical Center in Philadelphia have found that cocaine-exposed children in a low-income, inner-city cohort tend to have similar IQs to children not exposed to cocaine. However, both groups of children had IQs lower than the national average, indicating that environment may have a more powerful effect on development than cocaine exposure.

The investigators stressed that their findings indicate there is hope for children exposed to cocaine in utero, but that they still usually require environmental interventions. (*Clinical Psychiatry News* 26:12, 1998)

A tribute to Dr. Benjamin Spock

By Robert Perloff, Ph.D.

As president-elect of the American Psychological Association (APA) it was my duty to designate a non-psychologist as the principal invited speaker for our 1984 annual convention. My selection was Benjamin Spock, because of (1) his laid-back, jargon-free and parent-friendly orientation to child rearing and (2) his dauntless opposition to nuclear derring-do and the nation's heedless intrusion into the Vietnam conflict. Hence, I was ecstatic over his acceptance of my invitation to address the 14,000 psychologists attending our convention in Toronto.

More than standing room only, the ballroom where Spock held forth was packed to the gills with latecomers desperately shoehorning themselves into the thronged auditorium. Otherwise blasé psychologists, among them young moms with infants in tow, clamored for his autograph and beseeched him for photo-ops showing him enfolding their babies and toddlers.

Spock not only delivered a mesmerizing speech, he also went far beyond his original obligation to the APA. He showed up at numerous social functions and other events held at the many APA convention sites in Toronto, enchanting us with stories about how he was carted off in paddy wagons with other Vietnam dissenters and enriching us with instructive episodes of his ministration as the world's most beloved pediatrician. He frolicked tirelessly, dancing away into the wee hours while exhausting adoring partners half his age and even younger.

Benjamin Spock, a *sui generis* piece of work, was then 81 years young, when many of his contemporaries were well into their dotage.

Robert Perloff is distinguished service professor emeritus of business administration and psychology at the University of Pittsburgh.

... stimulant abuse on the rise.

College students are increasingly abusing the stimulant drug methylphenidate (Ritalin) on campuses nationwide. According to an informal study conducted by students at the University of Wisconsin in Madison via the Internet, there is a black market for obtaining methylphenidate on some campuses, with some students paying $5 or $6 a pill for the drug. Some students are crushing the pills and sniffing the drug like cocaine.

Methylphenidate is a stimulant drug approved only for the treatment of attention deficit disorders.

Novartis, makers of the drug, sent information to several hundred thousand physicians and pharmacists last spring in an attempt to alert them to such abuses of methylphenidate.

"... For some college students, it has become as popular as Coca-Cola and coffee as a study aid," reports Chris Johnson, a sophomore at the University of Wisconsin.

What's New in Research

Obesity in young children predicts obesity as adults

At ages five to six, body fatness normally declines to a minimum, which is a point referred to as "adiposity rebound" (AR), before weight increases again into adulthood. Recent research found that an early AR is associated with an increased risk of adult obesity independent of parent obesity and the body mass index (BMI) at AR.

Researchers evaluated 390 patients in a retrospective cohort study using lifelong height and weight measurements recorded in outpatient medical records at Group Health Cooperative of Puget Sound in Seattle. Patients had at least one recorded adult height and weight measurement plus two visits with recorded height and weight measurements in each of three age intervals: ages 1.5 to 4, 4 to 8, and 8 to 15 years.

The researchers calculated the average BMI of each person during young adulthood (ages 21 to 29 years) and the BMI of the parents when each person was 1.5 years old. Adult obesity was defined as having a BMI of $\geq$ 27.8 for males and $\geq$ 27.3 for females. The people were divided into groups by age at AR, BMI at AR, and parent BMI.

The average age at AR was 5.5 years, and 15 percent of the cohort was obese in young adulthood. Adult obesity rates were higher in patients with early vs. late AR (25 percent vs. 5 percent), in patients who were heavy instead of lean at AR (24 percent vs. 4 percent), those with heavy vs. lean mothers (25 percent vs. 5 percent), and those with heavy vs. lean fathers (21 percent vs. 5 percent). After adjusting for parent BMI and BMI at AR, there was a six-fold increase in adult obesity associated with early vs. late AR.

"An early AR is associated with an increased risk of adult obesity independent of parent obesity and the BMI at AR," say the researchers.

"Early adiposity rebound and the risk of adult obesity," R.C. Whitaker, M.S. Pepe, J.A. Wright, et al., *Pediatrics* 101:5, 1998. For reprints, contact Robert C. Whitaker, M.D., Children's Hospital Medical Center, Division of General and Community Pediatrics, CH-1S, 3333 Burnet Ave., Cincinnati, OH 45229-3039.

Smoke linked to middle-ear disease

Researchers say that environmental tobacco smoke is an important risk factor for middle-ear disease in urban preschool-age children, even in a relatively affluent population.

The researchers conducted a study of 1,320 first-grade students in 36 schools in Calgary, Alberta, Canada to determine the effects of environmental tobacco smoke and middle-ear disease in preschool children. The parents of 625 children were interviewed by telephone as well.

The researchers found relationships between middle-ear disease and two or more household smokers, 10 or more cigarettes smoked by the mother per day, and 10 or more cigarettes smoked in total in the household per day during the first three years of life.

"Environmental tobacco smoke and middle ear disease in preschool-age children," C.E. Adair-Bischoff, R.S. Sauve, *Archives of Pediatrics and Adolescent Medicine* 152:127-133, 1998. For reprints, contact Carol E. Adair-Bischoff, Ph.D., University of Calgary, 3230 Hospital Drive NW, Calgary, Alberta, Canada T2N 4N1.

Resources

Video catalog offers programs on guidance topics for teens

The Bureau for At-Risk Youth is offering a 60-page, special edition video/multimedia catalog that lists hundreds of video and CD-ROM products on hard-to-find guidance topics. The programs feature IBM and MAC software.

Some of the topics covered in the catalog are as follows:

- Drug prevention.
- Sexually transmitted diseases.
- Parent education.
- Teen pregnancy.
- Interview and job search skills.
- Decision-making and other life skills.
- Community advocacy.
- Peer pressure.
- School success.
- Building self-esteem.

The bureau's newest interactive CD-ROM program is for preteens and teens. Titled "Dangerous Drugs 101," the six-program series is designed to empower young people to make no-use decisions about drugs. For a free copy of the spring/summer 1998 Video/Multimedia catalog, write to The Bureau for At-Risk Youth, P.O. Box 760, Plainview, NY 11803-0760; phone (800) 999-6884.

Jonesboro
from page 1

lion children under 14 years of age in the United States, the rate of youthful homicides is nearly zero. Fewer than 50 homicides occur in schools each year, compared to the 20,000 homicides that occur off school grounds.

In short, while we can perhaps learn a great deal about what happened, these tragedies are so unusual that it is extremely difficult to learn much about why they occur. Simply stated, unthinkable events occur and our knowledge is often simply not adequate to explain them. The sound bites offered up by actual (and self-proclaimed) experts on youth violence, school violence and mass murder may represent the full extent of what we know about what causes children to kill children. While we may want to know more, it may be no more possible to provide a complete explanation for Jonesboro than it is possible to explain why a tornado set down on one side of a street and not another.

Yet, such a conclusion leaves an emptiness. Reason suggests there ought to be something more than a superficial explanation or saying "I don't know" following the Jonesboro tragedy. While the following is not a full explanation, it may be worth considering.

The need for feeling a part of society

What seems to be a common thread among the cases of children who kill children, whether the act occurs in a schoolyard, at home or even on the street, is a disturbing lack of connectedness between these violent children and the society and institutions that are supposed to care for and watch out for them.

The two boys in Jonesboro were alarmingly free to skip school, take a van, go from house to house looking for guns, break into a home and secure guns and ammunition, and then proceed to the school and the killings. No one seemed to be available to supervise these boys' activities at home, and no one at school seemed to be able to follow up on the boys' absence from school.

Despite whatever psychological and social factors might have motivated the boys to kill, despite the fact that guns and ammunition were available, there could and should have been a number of roadblocks and constraints to head off the final tragedy. If only there had been some person or persons who might have acted as social connections watching over and supervising these two youngsters. If only a parent had been available to supervise the boys. If only the school had been more reactive in tracking down absent students. If only the school had been more proactive in identifying and dealing with troubled students. But none of these were the case. One boy's parents were both at work; the other boy's parents were divorced. The school, like most schools in this country, limited its involvement with the children to what went on within the building or on the grounds.

A lack of social capital

The late James Coleman talked about the importance of what he called "social capital," the norms, networks and relationships between adults and children that are of value for a child's growing-up. Drawing from my own interviews and studies of a number of homicidal offenders younger than 14, my one consistent finding is that these children, wherever they live and whatever weapon they use, all lack social capital. Guns, TV violence and other simple and convenient explanations notwithstanding, unless and until we can meet the social capital needs of our youngest, most vulnerable and most dependent children, we will neither understand nor be able to prevent the unusual and unthinkable. ■

Richard J. Gelles is director of the Center for the Study and Prevention of Intimate Violence at the University of Rhode Island. He is the author of several books on intimate and interpersonal violence, including "The Book of David" (New York: Basic Books, 1996; (800) 331-3761).

Recommended Reading

CLINICAL AND FORENSIC INTERVIEWING OF CHILDREN AND FAMILIES — *J.M. Sattler. San Diego: Jerome M. Sattler Publishing Inc. 1,135 pages, $70 (hardcover), 1998. (619) 460-3667*

This encyclopedic volume is a monumental production in size and in intellectual and clinical scope. It is exceptionally well-referenced and well-indexed, and is organized to be of immediate help to the practitioner seeking data on maltreatment, neglect or other adverse conditions of early growth and development. It is a handbook and a guide, and can be an invaluable resource for all professionals who interview both victims and perpetrators.

RECOVERED MEMORIES OF ABUSE: TRUE OR FALSE? — *J. Sandler & P. Fonagy (Eds.). Madison, CT: International Universities Press. 250 pages, $55 (hardcover), 1998; (800) 835-3487.*

Provocatively titled, this book is based on proceedings of a 1994 conference on the validity (or not) of recovered memories of abuse. A collection of papers is presented, then followed by the editor's psychoanalytic approach to the issue of the existence of recovered and false memories.

Emotional, social skills

from page 1

than their better-off peers. They have more behavior problems, such as throwing frequent tantrums and destroying things, a trend that continues through the teen years. The press of poverty corrodes family life, too: In poor families there tend to be fewer expressions of parental warmth, more depression in mothers (who are often single and jobless) and a greater reliance on harsh punishments such as yelling, hitting and physical threats.

Some have a core of resilience

But there is a role that emotional competence plays over and above family and economic forces — it may be decisive in determining the extent to which any given child or teenager is undone by these hardships or finds a core of resilience to survive them. Long-term studies of hundreds of children brought up in poverty, in abusive families or by a parent with severe mental illness show that those who are resilient even in the face of the most grinding hardships tend to share key emotional skills. These include a winning sociability that draws people to them, self-confidence, an optimistic persistence in the face of failure and frustration, the ability to recover quickly from upsets and an easygoing nature.

Long-term studies of hundreds of children brought up in poverty, in abusive families or by a parent with severe mental illness show that those who are resilient even in the face of the most grinding hardships tend to share key emotional skills.

But the vast majority of children who face such difficulties are without these advantages. Of course, many of these skills are innate, the luck of genes — but even qualities of temperament can change for the better. One line of intervention, of course, is political and economic: alleviating the poverty and other social conditions that breed these problems. Apart from such tactics (which seem to move ever lower on the social agenda), there is much more that can be offered to children to help them grapple better with such debilitating hardships.

Take the case of emotional disorders, afflictions that about one in two Americans experience over the course of their lives. A study of a representative sample of 8,098 Americans found that 48 percent suffered from at least one psychiatric problem during their lifetime. Most severely affected were the 14 percent of people who developed three or more psychiatric problems at once. This group was the most troubled, accounting for 60 percent of all psychiatric disorders occurring at any one time, and 90 percent of the most severe and disabling ones. While they need intensive care now, the optimal approach would be, wherever possible, to prevent these problems in the first place.

To be sure, not every mental disorder can be prevented — but there are some, and perhaps many, that can. Ronald Kessler, Ph.D., the University of Michigan sociologist who did the study, told me, "We need to intervene early in life. Take a young girl who has a social phobia in the sixth grade, and starts drinking in junior high school to handle her social anxieties. By her late 20s, when she shows up in our study, she's still fearful, has become both an alcohol and drug abuser and is depressed because her life is so messed up. The big question is, what could we have done early in her life to have headed off the whole downward spiral?"

The same holds, of course, for dropping out or violence, or most of the litany of perils young people face today. Educational programs to prevent one or another specific problem such as drug use and violence have proliferated wildly in the last decade or so, creating a mini-industry within the education marketplace. But many of them — including many of the most slickly marketed and most widely used — have proven to be ineffective. A few, to the chagrin of educators, have even seemed to increase the likelihood of the problems they were meant to head off, particularly drug abuse and teen sex.

Information is not enough

An instructive case in point is sexual abuse of children. As of 1993, about 200,000 substantiated cases were reported annually in the United States, with that number growing by about 10 percent each following year. And while estimates vary widely, most experts agree that between 20 and 30 percent of girls and about half that number of boys are victims of some form of sexual abuse by age 17 (the figures rise or fall depending on how sexual abuse is defined, among other factors). There is no single profile of a child who is particularly vulnerable to sexual abuse, but most feel unprotected, unable to resist on their own and isolated by what has happened to them.

Basic training is not enough

With these risks in mind, many schools have begun to offer programs to prevent sexual abuse. Most such programs are tightly focused on basic information about sexual abuse — teaching kids, for example, to know the difference between "good" and "bad" touching,

Key ingredients of effective prevention programs

Emotional skills:

- Identifying and labeling feelings
- Expressing feelings
- Assessing the intensity of feelings
- Managing feelings
- Delaying gratification
- Controlling impulses
- Reducing stress
- Knowing the difference between feelings and actions

Behavioral skills:

- Non-verbal — communicating through eye contact, facial expressiveness, tone of voice, gestures, etc.
- Verbal — making clear requests, responding effectively to criticism, resisting negative influences, listening to others, helping others, participating in positive peer groups

From *Emotional Intelligence: Why It Can Matter More than IQ*. © 1995 by Daniel Goleman. Used by permission of Bantam Books, a division of Bantam Doubleday Dell Publishing Group Inc. Original source: W.T. Grant Consortium on the School-Based Promotion of Social Competence, "Drug and Alcohol Prevention Curricula," J. David Hawkins et al., *Communities that Care* (San Francisco: Jossey Bass, 1992).

alerting them to various dangers and encouraging them to tell an adult if anything untoward happens to them. But a national survey of 2,000 children found that this basic training was little better than nothing — or actually worse than nothing — in helping children do something to prevent being victimized, whether by a school bully or a potential child molester. Worse, the children who had received only such basic training and who had subsequently become victims of sexual assault were actually *half* as likely to report it afterward than were children who had had no programs at all.

In contrast, children given more comprehensive training — including related emotional and social competences — were better able to protect themselves against being victimized: they were far more likely to demand to be left alone, to yell or fight back, to threaten to tell and to actually tell if something bad did happen to them. This last benefit — reporting the abuse — is preventive in a telling sense: Many child molesters victimize hundreds of children. A study of child molesters in their 40s found that, on average, they had one victim a month since their teenage years. A report on a bus driver and a high-school computer teacher reveals they molested about 300 children each year between them — yet not one of the children reported the sexual abuse; the abuse came to light only after one of the boys who had been abused by the teacher started to sexually abuse his little sister.

Those children who received the more comprehensive programs were three times more likely than those in the minimal programs to report abuse. What worked so well? These programs were not one-shot situations, but were given at different levels several times over the course of a child's school career, as part of health or sex education. They enlisted parents to deliver the message to the child along with what was taught in school (children whose parents did this were the very best at resisting threats of sexual abuse).

Beyond that, social and emotional competences made the difference. It is not enough for a child simply to know about "good" and "bad" touching; children need the self-awareness to know when a situation *feels* wrong or distressing long before the touching begins. This requires not just self-awareness, but also enough self-confidence and assertiveness to trust and act on those feelings of distress, even in the face of an adult who may be trying to reassure her that "it's OK." And then a child needs a repertoire of ways to disrupt what is about to happen — everything from running away to threatening to tell. For these reasons, the better programs teach children to stand up for what they want, to assert their rights rather than be passive, to know what their boundaries are and to defend them.

The most effective programs, then, supplement basic sexual-abuse information with essential emotional and social skills. These programs teach children to find ways to solve interpersonal conflicts more positively, to have more self-confidence, not to blame themselves if something happens and to feel they have a network of support in teachers and parents whom they can turn to. If something bad does happen to these children, such programs make it so they are far more likely to tell. ■

Daniel Goleman, Ph.D., is the author of *Emotional Intelligence: Why It Can Matter More than IQ*. © 1995 by Daniel Goleman. Used by permission of Bantam Books, a division of Bantam Doubleday Dell Publishing Group Inc.; ISSN # 0-553-37506-7; 353 pages, $23.95 (hardcover). Available at bookstores everywhere.

Commentary

Do I dare go to Jonesboro?

Incensed though I was over the waste of young, innocent lives in Jonesboro, to say nothing of that of the children's heroic teacher, I restrained myself from going public with my impressions, which at first I deemed no better informed than anyone else's.

Preaching about the inadequacies and insufficiencies of behavioral and social scientists at times like these strikes me as futile at best, and as narcissistic professionalism at its worst. We don't know enough to understand these human perils in our midst, and I am not sure that the roots of such horrific destinies as those of these children will ever be understood, even by learned scholars and psychological clinicians.

Any observant and thinking person can say that if the guns weren't available to these youngsters, and they hadn't been taught to use them, there wouldn't have been five innocent people killed. That's a distinctively American problem; we have the highest gun-related death rate among young people in the world. With time and, I hope, the accruing of wisdom as impassioned outrage subsides, I have come to feel differently about stepping forward.

I will be damned if we do not know something about the origins of that terrible Jonesboro day. I am now rather more aggressive about this point of view that I knew lurked there, even as I declined those 35-second interviews.

We may not know precisely — and maybe we never will know — what the converging specifics of the situation were that led to the childhood massacre in Jonesboro. We do know, however, about many of the factors in early childhood, family life and community conditions that conspire to create mayhem in the minds of young people. These adversities wreak havoc on children and, in turn, on their families and, in the worst possible circumstances, condemn those who are touched by them to an enduring living hell.

Elsewhere in this newsletter, childhood-violence expert Richard Gelles, after a brief demurral, proposes an "explanation," even as he admits that experts are quite unable to predict which individuals are going to commit heinous crimes. For Professor Gelles, there is first an unfortunate statistical fact: There always has been and thus will perhaps always be, in every culture, a low-level baseline incidence of severe mental derangement and behavior disorder. This base will move lower or higher depending upon the conditions of the culture. Some cultures simply tolerate higher doses of aggressive behavior. Conditions prevail in those cultures such that acting out one's aggressive fantasies is more tolerated. Permissiveness with respect to gun presence, weapon ownership and valuation on marksmanship are perhaps among the features of a culture that has a high tolerance for aggression.

But the milieu, the social context, the "surround," is not enough of an explanation for me. Lots of children are brought up with guns around them, and they do not attack other children. Many children grow up in hostile environments without becoming murderers or abusers. Who can read Frank McCourt's *Angela's Ashes* without appreciating this?

While I understand the importance of the social contexts in which children are reared, I am putting most of my money on the personal experience of the individual child.

While I understand the importance of the social contexts in which children are reared, I am putting most of my money on the personal experience of the individual child. Every child must be born into the arms of someone who loves him or her deeply. Every child must have someone who takes him or her by the hand, literally and in spirit, and protects that child not just from the rest of the world, but from himself or herself. Every child must have someone *to whom he or she can go* — or who will come to that child on a sensed occasion of need.

This is the stuff of which a child's attachment to others is made. First, the bond is with some significant other who takes good care. Then that bond is transferred to others, with the permission of the initial caregiver. When the transfer is truly effective, the child grows to love and respect others. He could never kill another person, even at the age of 11 or 13.

Lewis P. Lipsitt

ISSN 0898-2562

The Brown University Child and Adolescent Behavior Letter

Providing the link between behavioral research and your clinical work.

Social Development

To foster children's self-esteem and resilience, search for islands of competence

By Robert B. Brooks, Ph.D.

Success in one arena of a child's life can serve as the foundation for success in other areas. Therefore, in order to design interventions that will enhance self-esteem and resilience in children, we must first identify and reinforce what I call their "islands of competence," so that a ripple effect may be created, motivating children to venture forth and confront the tasks they have previously found difficult.

Resilient children have in their lives the presence of adults who focus on their islands of competence.

Self-esteem may be understood as including the feelings and beliefs that individuals have about their abilities to make a positive difference, to confront rather than retreat from challenges, to learn from both success and failure and to treat themselves and others with respect.

In the beginning of my career, a number of my psychology courses focused on pathology. Also, the dominant theory of the day held that by the time children were five or six years old, their basic personalities were set. What a climate this created, a climate filled with pessimism about the future success of children with problems. We gave youngsters diagnostic labels that were similar to tattoos — almost impossible to remove even with the passage of time. What made this especially unfortunate was that, in

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Case Study

A schizophrenic mother's behavior confuses her young child

By Jeffrey A. Botman, Ph.D.

Every child therapist has asked this strategic question: To what extent can a child resolve her problems on her own — absent the cooperation of significant adults in her life? Generally speaking, the younger the child, the lesser her power and the greater her dependency upon adults for help in implementing changes that will resolve her problems. Thus, a young child's difficulties are especially complicated when one of her parents is constrained in his/her capacity for change by major psychiatric illness.

Psychiatrically impaired parents may not only lack resources to implement therapeutic strategies in their child's life, they also may unwittingly exacerbate her difficulties. Such parents may err in judging risks to the child, in representing social mores to the child and in interpreting the child's affects and intentions. For example, phobic parents might impose unnecessary restrictions upon their children in situations that would safely permit autonomous functioning. Borderline parents may confuse and scare their

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The Brown University Child and Adolescent Behavior Letter

Editor: Lewis P. Lipsitt, Ph.D.
Professor Emeritus of Psychology, Medical Science, and Human Development at Brown University

Contributing Editors:

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Carol Lewis, M.D., Clinical Instructor in Pediatrics, Brown University School of Medicine; private practice

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Keep Your Eye On ...

... trampolines and injuries.

The number of trampoline-related injuries to children 18 years old and younger almost doubled from 1990 to 1995, according to a study from Ohio State University and Children's Hospital in Columbus, Ohio.

The study reports that the number of trampoline-related injuries treated in hospital emergency departments in the United States increased by 98 percent from 1990 to 1995, from 29,600 to 58,400. The research, led by Gary Smith, M.D., included data from the Consumer Product Safety Commission and discovered that more than 90 percent of the almost 250,000 injuries that occurred over the six-year study period took place on home trampolines.

Smith notes that the number of injuries found in his study is more than twice the number of baby walker-related injuries treated in emergency departments during the same time. He recommends that trampolines not be used at home by children and that the sale of trampolines for private use be stopped. The American Academy of Pediatrics recommends that trampolines never be used in home or recreational settings. (*Pediatrics*, March 1998.)

... attention deficit hyperactivity disorder.

Ohio researchers have developed a new intelligence test to help diagnose attention deficit hyperactivity disorder (ADHD). Called the Cognitive Assessment System (CAS), the test was developed by Jack A. Naglieri, Ph.D., professor of school psychology at Ohio State University in Columbus.

In a study presented at the annual meeting of the American Psychological Association, Naglieri and colleagues administered CAS to 60 children ages six to 13 who met psychiatric criteria for ADHD. When given the CAS, children with ADHD scored significantly lower than average in a measurement of planning ability — the ability to determine, select and use a strategy to efficiently solve a problem.

"Children with ADHD have a problem with self-regulation and inhibiting their behavior," Naglieri says. "And that's what planning is — the ability to control behavior. So it's not surprising that the planning scale on CAS is effective in identifying ADHD."

Typically, traditional intelligence tests can't effectively detect ADHD, he adds. For example, the Wechsler intelligence test has been used to identify ADHD, even though evidence for its effectiveness has not been found. CAS also can separate children with ADHD from children with problems such as learning disabilities, says Naglieri.

"Many experts believe there are too many children being diagnosed with ADHD," he notes.

CAS is based on a theory of intelligence developed by Naglieri, which argues that intelligence is based on the ability to plan, pay attention, integrate and relate information, and perform

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actions in specific order. CAS is available from Riverside Publishing, 425 Spring Lake Drive, 60143; phone (800) 323-9540. (The Ohio State University)

... baby fat and obesity.

The earlier children lose their baby fat and reach the leanest point of their growing-up years, the more likely they are to become obese later in life. Researchers at Children's Hospital Medical Center in Cincinnati found that all children appear to grow leaner after the first year of life until ages 5 to 6, when they become fatter again. The age of greatest leanness is called "adiposity rebound." Among three group of 390 patients who were tracked into adulthood, adiposity rebound was most likely to occur before age 6.2. The findings suggest that there may be a biological component to obesity in children at a young age. (*American Academy of Pediatrics)*

... new autism centers.

The National Alliance for Autism Research in Princeton, N.J., is proposing that five new Centers for Research in Autism Epidemiology be established. The centers will study the causes and prevalence of autism, and will focus on the genetic and environmental factors that may play a role in autism. The organization reports that autism is the nation's third most common childhood developmental disability, and although it affects about one in 700 children, little research has been conducted in the United States on the disorder. The centers would be located in five different areas of the country. The Centers for Disease Control and Prevention would provide epidemiologic studies for the project, which will require $13 billion in federal funding per year. The Alliance is currently presenting its proposal to CDC. (*PR Newswire)*

... stressed babies.

Harvard researchers report that there may be a physical basis for personality disorders in childhood based on the amount of stress infants experience. Babies who sleep alone or are not picked up and comforted may become susceptible late in life to post-traumatic stress disorder (PTSD) and personality problems. The researchers also report higher levels of the stress hormone cortisol in babies who cry. Infants who are not picked up and comforted cry more, so they have higher levels of cortisol, which may cause neurological changes that later lead to PTSD and other disorders. (*Reuters)*

... teen sexual abuse.

Girls who were sexually abused as children are far more likely both to practice risky sexual behavior and to become pregnant as adolescents, according to a study from the National Institute of Mental Health. The study is the first to document the connection between teen pregnancy/risky sexual behavior and high rates of prior sexual abuse by looking at psychological development of sexually abused girls from adolescence to adulthood.

The study's investigators report that not only were sexually abused girls more likely to have babies, they also were more likely to be sexually active at a younger age, and had more children than did girls

Recommended Reading

ATTACHMENT AND PSYCHOPATHOLOGY — *L. Atkinson and K.J. Zucker (Eds.). New York: Guilford Press. 328 pages, $36.95 (hardcover), 1997; (800) 365-7006.*

An excellent collection of chapters by some very distinguished investigators and clinicians dealing with problems of bonding, attachment and failures of attachment. Authors include Michael Rutter, Susan Goldberg, Inge Bretherton, Mark Greenberg and Charles Zeanah.

THE DICTIONARY OF MANAGED BEHAVIORAL HEALTH CARE — *J. Aronson. Bristol, Pa.: Brunner/Mazel (Taylor and Francis Group). 50 pages, $9.95, 1997; (800) 825-3089.*

Mental health professionals are challenged today to know the meanings of basic industry terms in managed care, such as managed indemnity, prospective fees and concurrent review. This handy book provides concise definitions of hundreds of frequently used words and phrases.

THE MANAGED CARE ANSWER BOOK FOR MENTAL HEALTH PROFESSIONALS — *G.M. Tuttle and D.R. Woods. Bristol, Pa.: Brunner/Mazel (Taylor and Francis Group). 152 pages, $21.95, 1997; (800) 825-3089.*

Complementary to the Aronson volume, above, the authors draw upon extensive experience to answer such managed care questions as "How do I get paid?" "What is triangulation?" and "Must economic/business rules dictate how quality care is delivered?"

who had not been abused. The findings were not affected by socioeconomic status.

The study examined 160 girls in Washington, D.C., area, who were six to 16 years old when the 10-year study began. Half of the group had been sexually abused.

Fifteen (24 percent) of the sexually abused girls had borne at least one child compared to eight (9 percent) of the girls who were not abused.

The average age of the sexually abused group was 18 when the girls gave birth to their first child compared to age 20 in the nonabused group.

The sexually abused girls reported having voluntary sexual intercourse a year earlier (on average, at 14.6 years old) than the comparison group did (15.6 years old).

More research is planned to assess how the trauma and stress of sexual abuse could be mediated by support from family, peers and therapists. (*University of Southern California News*)

What's New in Research

Children of bipolar parents have more affective illness

In a pilot study undertaken to describe the initial course of psychiatric illness in adolescent children of parents with bipolar disorder, researchers found the following: Psychiatrically ill children of lithium-responsive parents tended to have affective disorders that remitted and followed a recurrent course, and psychiatrically ill children of lithium-nonresponsive parents showed a broad range of psychopathology. They also had high rates of comorbid illnesses and had nonremitting affective illnesses.

Patients were divided into two groups on the basis of their response to long-term lithium monotherapy. Parents met Research Diagnostic Criteria for bipolar illness and met predetermined criteria for a clear response or nonresponse to lithium prophylaxis. Their adolescent offspring were interviewed using the Schedule for Affective Disorders and Schizophrenia for School-Age Children. Final diagnosis was made by blinded consensus.

The authors conclude that their findings suggest that family history and course of illness are important factors in diagnosing and treating affective disorders.

Duffy A, Alda M, Kutcher S, et al. Psychiatric symptoms and syndromes among adolescent children of parents with lithium-responsive or lithium-nonresponsive bipolar disorder. *American Journal of Psychiatry* 1998; 155:431-433. For reprints, contact Dr. Alda, Affective Disorders Service, Royal Ottawa Hospital, 1145 Carling Ave., Ottawa, Ontario, Canada, K1Z 7K4.

Drug users progress to antisocial personality

A recent study suggests there is a high rate of progression to antisocial personality disorder among substance-abusing adolescents.

A prospective, longitudinal study of 137 adolescents investigated the progression from conduct disorder to antisocial personality disorder among youths treated for substance abuse. The study was undertaken because of poor outcomes among antisocial adolescents with a history of alcohol or drug abuse.

The study participants' average age was 15.9 years, with each meeting the DSM-III-R criteria for conduct disorder. Participants were recruited from two adolescent inpatient alcohol and drug treatment facilities. They were interviewed during treatment and four years afterward.

Four years after treatment, 61 percent of the study group met the DSM-III-R criteria for antisocial personality disorder. Adolescents with antisocial personality disorder were more likely to have onset of deviant behavior at or before age 10, a greater diversity of deviant behavior and more extensive pretreatment drug use. After four years, those with antisocial personality disorder showed more involvement with alcohol and drugs and had poorer psychosocial functioning than did those without antisocial personality disorder.

In order to help develop appropriate treatments and interventions, the authors recommend a careful assessment of conduct disorder history when adolescents are treated for substance abuse.

Myers MG, Stewart DG, Brown SA. Progression from conduct disorder to antisocial personality disorder following treatment for adolescent substance abuse. *American Journal of Psychiatry* 1998; 155:479-485. For reprints, contact Dr. Myers, Psychology (116B), VA Medical Center, 3350 La Jolla Village Drive, San Diego, CA 92161.

Drug for bedwetting can cause dehydration

The authors of a recent report warn that when using desmopressin (DDAVP), children may become dehydrated unless the starting dosage is low.

A 10-year-old boy had been receiving 40 mcg of intranasal des-

"Winning is everything"

A societal belief that results in fear of effort, error, failure and pain

Throughout a child's development, he is faced with many new experiences that offer him an abundance of opportunities for both success and failure. Because these events are initially unfamiliar and require new skills, he may fear them on first encounter. For instance, a young baby may worry about his first bath or the falls and bumps he experiences while learning to walk. An older child might fear his first attempts at riding a bicycle, understanding math or spending the night with friends. And the teen may fear team tryouts or his first date. Yet even though unfamiliar events evoke normal feelings of uneasiness in both children and adults, the fear is meant only to help us become more alert and prepare for the new experience. When viewed in this context, we are able to more easily confront the fear and penetrate whatever barriers it creates for us.

This moment of confronting our fears can best be seen in the child standing on the edge of a diving board for the first time, looking down at the water below with fear pounding in his heart. Under normal conditions, children will make the decision to accept the fear as they leap to the water below. In this risk-taking act, they discover the excitement of full participation and realize that their fears have dissolved by the time they reach the water. The very act of jumping shows them how to overcome their fear. By confronting their fear and experiencing the jump and its accompanying success, they strengthen their feelings of internal power. As a result, any reluctance they might have had to facing the risks that go with participation is conquered.

However, when children have been made to feel afraid of participation or the effort, error, rejection and pain that it can bring, they will look at the water below, overrespond to the fear and shrink from the experience. As these children retreat to the stairs to escape the dreaded plunge, their fear grows.

That childhood jump offers a metaphor for how children negotiate their fears, and the way they manage will depend on what they have been taught. Those who have learned to embrace their fears will value participation, even when things are new and unpredictable and mistakes are a possibility.

Once a child is immersed in the participatory side of life, his fear dissolves and pleasure takes over as he

Choosing between avoidance and participation

The illusion: Avoidance will offer an easier road.

EASY ROAD

AVOIDANCE

Retreats from fear

- Avoids life
- Resists life's activities
- Hides from effort, error, rejection and pain
- No opportunity for success, growth, aliveness, fulfillment and joy
- Fear intensifies and feelings of resistance, inadequacy, helplessness, immaturity, dependence, powerlessness and low self-esteem develop
- Experiences the emptiness of avoidance

HARD ROAD

PARTICIPATION

Pushes through fear

- Participates in life
- Chooses life's activities
- Exposed to effort, error, rejection, hurt and pain
- Exposed to opportunity for success, growth, aliveness, fulfillment and joy
- Fear dissolves and feelings of competence, adequacy, strength, maturity, independence, personal power and high self-esteem develop
- Experiences the fullness of participation

The reality: The signs have been switched. Avoidance turns out to be the hard road.

HARD ROAD **EASY ROAD**

experiences the successes that go with involvement. He soon realizes that the choice for participation offers him abundant opportunities to learn from his experiences, which include effort, failure and pain as well as the successes, pleasure and skill-building he seeks.

By contrast, children pushed by parents in the race to the "top" develop fears about "making it" and "winning." Because they are often criticized for their choices and mistakes by their families, they learn to dread effort, error, rejection and pain. As a result, they become fearful of jumping and retreat down the stairs to the illusory safety of the avoider's corner. Although this seems like a good place to hide from life's challenges, this corner is so devoid of opportunities for success or fulfillment that it ultimately proves harder than the participation they were striving to avoid. Over time, these children become the resisters and avoiders in life, fearful of venturing out, and are left with narrow options and empty feelings of inadequacy and dependence. What these avoiders and resisters fail to notice is that without participation, there are no opportunities for success and the feelings of competence and joy that go with them. In short, the corner that shields them from fear, effort, error and pain becomes a lonely place to hide from life's offerings.

The key to getting back on the track to full participation lies in eliminating the idea that life is a competition among isolated individuals, all striving to the best in order to win. If we replace this fragmenting, fear-based goal with working together to create a better world, our children can become full participants in life's experiences.

Some parents take the desire for their children to reach the top to another level. Not only do they want the best for their children, they want them to have everything without experiencing any of the difficulty or pain involved in attaining it. As a result, they teach their children to be overly careful; side with them against the unfairness of life's difficulties; protect them from normal amounts of pain; and allow — even encourage — them to resist the usual effort and work that are a natural part of a full life. Not surprisingly, these children grow excessively fearful of normal amounts of difficulty and learn to withdraw from the activities that require effort.

Consequently, children of protective parents also retreat to the stairs to avoid jumping into life with full participation. Yet with each retreat they grow increasingly timid, while reluctance, resistance, avoidance and procrastination become their primary ways of coping. In the end, the overprotected child also lacks a toughness of spirit and the ability to push through barriers to meet his goals and soon finds himself among the other avoiders and resisters.

The fortunate child who has been taught that fear and pain are a normal part of life and can be confronted, welcomed and embraced will barely notice the newness of his experiences. Such a child will easily and eagerly push through his fears, particularly when he is provided with stepping stones to success when needed. Once he is there, his fear will dissolve as he willingly immerses himself in life's adventures. As a result, he becomes progressively more comfortable with new experiences as fear fades into an imperceptible backdrop of his life.

Adapted with permission. *Parachutes for Parents: 12 New Keys to Raising Children for a Better World*, Bobbie Sandoz, Contemporary Books, 1993. To order, call (800) 323-4900.

The Brown University **Child and Adolescent Behavior Letter**

Editor's Note: Subscribers are permitted to photocopy multiple copies for clients and colleagues who would benefit from the material. Not for resale or mass distribution. This article first appeared in *The Brown University Child Behavior and Development Letter* in 1991. We are reprinting it as a service to our readers.

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mopressin to treat nighttime bedwetting. He had been taking desmopressin for three weeks without experiencing any bedwetting or adverse side effects when he had a seizure and was seen in a hospital emergency department. Doctors there found that he had low blood sodium levels indicating an electrolyte imbalance, which is a side effect of desmopressin therapy.

The authors recommend starting children on the lowest possible dose (10-20 mcg) of desmopressin to minimize the risk of dehydration.

Donoghue MB, Latimer ME, Pillsbury HL, et al. Hyponatremic seizure in a child using desmopressin for nocturnal enuresis. *Archives of Pediatric and Adolescent Medicine* 1998; 152:290-292. For reprints, contact James H. Hertzog, M.D., Division of Pediatric Critical Care and Pulmonary Medicine, Georgetown University Medical Center, CCC-5414, 3800 Reservoir Road NW, Washington, DC 20007-2197.

Self-esteem

from page 1

many instances, the diagnostic label became synonymous with the child so that we lost sight of his or her many positive qualities.

However, as I shifted my focus to self-esteem, as I embraced a more positive perspective and as I interviewed many people who had experienced significant problems as youths but were now leading satisfying lives as adults, I started to ask a question that was to become an important aspect of my work: "What are the factors that help at-risk children to overcome problems and become more resilient?" I assumed that the answer to this question would help us to develop and implement more effective intervention strategies to strengthen children's self-esteem and hope.

It is beyond the scope of this article to describe in depth the various strategies that can be used to foster self-esteem and resilience. However, a few important points can be noted. Resilient children appear to have more advanced problem-solving and decision-making skills and more adaptive coping behaviors than those who are not resilient. They also maintain a high level of self-esteem and a realistic sense of personal control over the path that their lives will take. The link between a positive self-image and resilience is one more reason for seeking ways to strengthen our children's self-esteem.

Each child needs a charismatic adult

Very importantly, resilient children have in their lives the presence of adults who believe in them, who encourage them, who support them and who focus on their strengths, or "islands of competence." Psychologist Julius Segal referred to such adults as "charismatic," noting that from them, children "gather strength." We must never underestimate the power of even one adult to guide a child's life in a more positive direction.

The fear of making mistakes and looking foolish is one of the strongest roadblocks to developing high self-esteem and resilience.

The four strategies listed here serve to illustrate what can be done on behalf of our children.

❶ Teaching responsibility by encouraging contributions

If children are to develop a feeling of accomplishment and pride, we must provide them with ample opportunities for assuming responsibilities, especially responsibilities that strengthen their belief that they are making a contribution to their homes, schools or communities. I have found that enlisting youngsters with ADD or LD to use their "islands of competence" in such pursuits as tutoring younger children, painting murals on the wall of the school, watering plants or taking messages to the office helps them to feel that they are making a positive difference, and serves to reinforce their motivation and self-esteem as they witness concrete examples of their achievements.

❷ Teaching decision-making and problem-solving skills and reinforcing self-discipline

An essential component of high self-esteem and resilience is the belief that one has some control over what is occurring in one's life. To acquire this attitude of ownership, children need experiences in which they can learn and apply decision-making and problem-solving skills.

This can be accomplished by involving children in discussions of how best to solve particular problems, or by having them decide which six or eight problems on a homework sheet they can select to do, or by enlisting their input in the development of rules and consequences that affect their lives at home and at school (children are often more likely to remember and

follow rules when they are involved, within reason, in the creation of these rules or consequences), or asking them to do research on a particular project. These kinds of activities empower children by reinforcing a sense of ownership, commitment, accountability and self-discipline.

❸ Offering encouragement and positive feedback

Self-esteem and resilience are nurtured when we convey realistic appreciation to children and help them to feel special. By doing so, we become the "charismatic adults" in their lives. Spending "special" time alone with children, writing them a brief note of appreciation or having a school assembly in which students are recognized for various accomplishments (not just academic achievement) are examples of this strategy.

❹ Helping children deal with mistakes

The fear of making mistakes and looking foolish is one of the strongest roadblocks to developing high self-esteem and resilience. Children with ADD and/or LD are often vulnerable to feelings of defeat and are likely to retreat from tasks that may lead to failure.

We must help children to realize that mistakes are an important ingredient in the process of learning. We can do this in various ways, such as responding to children's mistakes by showing them the correct way to solve a problem and avoiding such demeaning comments as, "Do you have any brains?" or "You never do anything right!"

As another example, at the beginning of the school year before teachers have taught any lessons or given any work, they can introduce the topic of mistakes in the learning process; in the discussion, teachers can share memories of their own anxieties about making mistakes when they were students and involve the class in a discussion about the best ways to ensure that no student will be worried about making a mistake. Placing the issue about the fear of making mistakes out in the open typically serves to lessen its potency, thereby increasing opportunities for learning.

A sense of optimism

In general, resilience is linked to a sense of optimism, ownership and personal control. What I have learned from both personal and professional experiences is that we can all serve as the "charismatic adults" in children's lives — believing in them and providing them with opportunities that reinforce their "islands of competence" and feelings of self-worth. This is truly a wonderful gift we can offer — it's our legacy to the next generation. ■

Robert B. Brooks is a clinical psychologist in private practice, a member of the faculty at Harvard University Medical School and a well-known speaker and author. His books include *The Self-Esteem Teacher*, which is one component of "The Seeds of Self-Esteem" project produced by Treehaus Communications and published by American Guidance Service. To order, call (800) 328-2560.

Brooks recently compiled a videotape and educational guide for the Public Broadcasting Service called "Look What You've Done." It's filled with stories of hope and resilience, and focuses on children with learning and attentional problems. Both the videotape and educational guide are available to teachers, parents and mental health professionals for $49.95. To order, call (800) 344-3337.

Case study
from page 1

children with dramatic shifts in attitude and tone that bear no simple, consistent relationship to interpersonal context.

Schizophrenic parents might mistakenly attribute anger and defiance to their children when they are simply showing age-appropriate initiative.

The following case illustrates two basic points:

- How a parent whose functioning is constrained by schizophrenia may undermine her child's efforts to achieve independent judgment and self-confidence.
- How a therapist may achieve a favorable outcome for a child even if her impaired parent will not participate in family treatment.

Andrea's dilemma

At the time of our first meeting, Andrea was a five-year-old girl whose mother had been diagnosed with paranoid schizophrenia. According to her father, Andrea had reportedly resumed bedwetting after months of continence. Around her mother, Andrea was reportedly becoming uncharacteristically glum and withdrawn. Moreover, when her father prepared to leave for work each morning, Andrea would hysterically plead that he remain at home.

Our interview suggested that Andrea's mother was misconstruing Andrea's age-appropriate expressions of autonomous will as acts of deceitfulness and defiance. When, for example, Andrea requested an early snack, her mother exploded: "What's wrong with you? Don't lie to me! I know you

can't really be hungry!"

When Andrea reached for a brand of cereal at the supermarket that her mother didn't want, her mother launched into a similar tirade.

I explained Andrea's problem to her father as follows: "Parents teach their children how to label, express and act on their feelings. Andrea is quite naturally looking to both you and her mother for reassurance that she is normal, healthy and good to have the feelings she does.

"Your wife's criticisms are undermining Andrea's basic self-trust. Take a familiar situation: Andrea feels hungry. She recognizes that a snack will satisfy her hunger. She requests a snack from her mother. So far, so good — until her mother accuses her of deceitfulness and defiance. Then Andrea becomes angry, confused and scared. Here's her bind. On the one hand, Andrea can't deny what she genuinely feels. On the other hand, she can't easily bear feelings that her mother invalidates. Andrea is left feeling lost and helpless. No wonder she is glum around her mother and scared when you leave for work."

Although I prefer treatment involving both parents, in this case it was simply not possible. Andrea's mother was highly distrustful of mental health professionals in general. She adamantly refused any participation in her daughter's therapy. Even her commitment to ongoing work with her own prescribing psychiatrist remained uncertain. Therapy, therefore, aimed to achieve several strategic ends simultaneously:

- Defusing conflict between Andrea and her mother.
- Strengthening the alliance between Andrea and her father.
- Bolstering Andrea's autonomy and self-confidence.
- Avoiding exacerbation of tensions between Andrea's parents.
- Supporting the alliance between Andrea's mother and her psychiatrist.

During five conjoint sessions alone with father and daughter, I orchestrated discussion of Andrea's specific interactions with her mother. My primary aim was to implement strategies two and three as listed above: to strengthen the alliance between father and daughter and to bolster Andrea's sense of autonomy and self-confidence. Toward that aim, I supervised Andrea's father in judging each of his wife's behaviors according to the following criteria:

- All mommies do that.
- Some mommies do that; some mommies don't do that.
- Mommies aren't supposed to do that. Mommy's sickness made her do it. Here's what Mommy should have done.

In addition, Andrea's father and I acknowledged as appropriate *elsewhere* those of Andrea's actions that her mother had unfairly disqualified.

To minimize risk for increased tension between Andrea's parents, I claimed responsibility for those events that were transpiring in treatment.

To minimize risk for increased tension between Andrea's parents, I claimed responsibility for those events that were transpiring in treatment. In a letter I sent to Andrea's mother, I recognized her efforts to raise a happy and healthy little girl and explained what father and daughter were doing in my office *at my insistence* to support her, the mother, in her efforts. Andrea's mother was also invited to contact me for an individual session, should she have questions or suggestions pertaining to my work *in her behalf* with her husband and daughter.

In support of the relationship between Andrea's mother and her psychiatrist, I sent a copy of that same letter to him, prior to our telephone consult (and after an authorization to release information was signed.)

In order to defuse tensions at home between mother and daughter, Andrea was supervised in role-plays within sessions that involved:

- Expressing requests to her mother in deferential terms: "Mommy, if you think it's OK, there's something I would like."
- Apologizing to her mother when her mother grew upset: "Mommy, I didn't mean to upset you. I'm sorry I did."

After five sessions within a two-week period, Andrea was circumventing a number of her mother's tirades and tolerating those that remained without either feeling hopelessly demeaned or having her judgment permanently disqualified. Her bedwetting ceased and her tantrums upon her father's departure for work stopped. Although her mother never called for an appointment, she did discuss Andrea's treatment with her own psychiatrist. Andrea's father incorporated conversations with his daughter into their daily home routine. ■

Jeffrey Botman is a licensed psychologist who specializes in strategic approaches to psychotherapy. While consulting and training throughout the New England area, he maintains his private practice in Cambridge, Mass.

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Guest Commentary

Every now and then, a somewhat frivolous-seeming piece with an underlying serious message comes to us and we like it so much that we think we ought not deprive our newsletter friends of it. If it weren't for the fact that it really has something to do with child developmentalists and adolescence experts, we would not be so generous in our sharing. We hope you like it, too. — Lew Lipsitt, Ph.D., Editor

Perhaps hormones, but certainly the human condition, deal preteens a stunning blow

By Hilary Cosell

She sulks, tossing her blond hair. She broods, narrowing her blue eyes. She fingers the thick silver chains looped around her neck like collars from the Humane Society. Doors slam. Matchbox 20 wails, "I want to push you around. I want to push you down. I want to take you for granted" at top volume from her radio. The lyrics are boy to girl, but they could easily be the way she often feels about me.

I am her mother. She is a preteen. Overnight, we're playing out the clichéd roles assigned to us by the psychiatrists, pediatricians and pathologists. They have it scripted to the second. Each slamming door, sigh, curse, triple pierce, body pierce, piercing cry stemming from a parent-inflicted injustice.

Everyone's got the script. American culture thrives on packaging the preteen and teenager as a special-needs group. The health care industry pockets a fortune dispensing therapy and medications for distraught teens and their equally distraught parents. Millions of dollars funnel annually from our pockets to the lords of teen music. Publishing houses churn out young adult fiction to reinforce the preteen and teen separateness, specialness and selfishness, and follow with the companion "how to" books for parents.

Before the "how to," though, these experts have a field day explaining why adolescents act so predictably and nastily. Hormones, hormones and more hormones always top the list of explanations for their behaviors. So does peer pressure.

No one can deny the effects of estrogen and testosterone. Thing is, those hormones never go away, do they? Ask any woman who's premenstrual, menstrual, pregnant, pre-menopausal or menopausal. Ask any man salivating over that apparent combination of silicone and scar tissue known as Pamela Lee or still flipping to the centerfold long after intercourse and the female body have ceased to be novelties. The damn chemicals harass us continuously, whether we're 14, 24 or 44. For that matter, so do our peers.

If hormones count so much, so does cognitive ability. If hormones are leaping through their bodies, their minds are surging through their souls. They haven't so much entered adolescence as they have left childhood behind. Recognizing for the first time that the cosmos is chaos and no one, not even Mom or Dad, can control it or protect them from it, is enough to make anyone run for booze or pills. But it isn't a temporary condition that will end when they fling their mortarboards into the air at college graduation.

Hormones may exacerbate it, but what is happening to these children as their minds and bodies grow is that they are confronting their world for the first time not as teenagers or adolescents, but as human beings.

Perhaps it sounds too simple, but the self-evident is often ignored. When I see a certain look on my daughter's face, I recognize loneliness has hit her, the chronic emptiness everyone suffers sometimes. She is young, inexperienced. She thinks she alone feels that aching void. Because her culture tells her she is a special class of person, entering a cordoned-off stage of life, her belief is wrongly reinforced.

Adults know that emptiness strikes us all our lives. It can hit you when you're peeling potatoes for dinner, or trading on the stock exchange floor. It grabs you by the throat anytime, any place and shakes you till your neck snaps, once you reach a certain age.

Who am I? Why am I here? Do my friends really like me? The lament changes with age and experience. The burning issue of what to wear to the middle school dance becomes how to dress for success. What underlies the lament does not.

I'm throwing out the script. I have a person in my house now. Not a child, not a preteen. I welcome her, even as I contemplate convent schools and military academies on the worst days. After all, it's the human condition. And now she and I are in it. Together. ■

Hilary Cosell is a writer, author and television producer living in Connecticut.

ISSN 0898-2562

The Brown University Child and Adolescent Behavior Letter

Providing the link between behavioral research and your clinical work.

Early Intervention

Early stimulation aids brain development, increases competence, decreases cost to society

By Max Cynader, Ph.D., and Fraser Mustard, M.D.

The 7,000 infants born this week are beginning the process of wiring their brains for a lifetime. How well they are able to do that will have a large influence on their behavior, their capacity to learn throughout the rest of their lives and their functioning as members of society.

Certain conditions enhance the infant's ability to carry out this crucial and delicate process. If society, parents and governments do not pay attention to these conditions, we will all suffer the consequences starting early in the next century.

It has been estimated that for every dollar this intervention program costs, the return after more than 20 years is at least seven dollars.

The new research in developmental neurobiology has shown that the stimulation the billions of undifferentiated neurons in the brain receive during early life has a major effect on their differentiation and function. These developments, in turn, have a significant effect on the competence and coping skills of individuals throughout the later stages of the life cycle. Competence can be considered to include what we have learned and our ability to learn. Coping encompasses how we respond to challenges and how we handle stress.

These advances in developmental neurobiology have progressed to the point that they can help our

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PS 02215

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New research finds that SSRIs may be beneficial to children with anxiety disorders.
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Adolescents ingesting baclofen suffer serious illness.
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Television-watching is linked with obesity in children.
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Guest Commentary: Taking time to talk with children and adolescents yields huge benefits.
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This month's client handout:
An optimistic look at the nature-nurture controversy

Self-Mutilation

Tattoos, body piercing are linked to psychiatric disorders in youth

By Theresa Waldron

A study of tattooing and body piercing indicates that those practices can be used to predict self-mutilating and dysfunctional social behavior, according to psychiatrists at East Tennessee State University in Johnson City.

Salvador Ceniceros, M.D., chief resident in the department of psychiatry, and colleagues designed a study to determine if psychiatric patients with tattooing or body piercing differed from psychiatric patients without those forms of body modifications in relation to depression, anxiety, self-mutilating behavior and dysfunctional social behavior. They also sought to determine if the severity and degree of body modification, such as total number and location of tattoos, could be used to predict self-mutilating and dysfunctional social behavior.

Forty psychiatric patients interviewed

Ceniceros interviewed 20 patients on the inpatient psychiatric unit with body modification and

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The Brown University Child and Adolescent Behavior Letter

Editor: Lewis P. Lipsitt, Ph.D.
Professor Emeritus of Psychology, Medical Science, and Human Development at Brown University

Contributing Editors:

Stephen L. Buka, Sc.D., Associate Professor, Department of Maternal and Child Health, Harvard University School of Public Health

Cynthia Garcia Coll, Ph.D., Professor, Education, Psychology and Pediatrics; Chair of Education Department, Brown University

Ferdinand Jones, Ph.D., Professor of Psychology, Brown University; formerly director of Brown University Student Counseling

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Carol Lewis, M.D., Clinical Instructor in Pediatrics, Brown University School of Medicine; private practice

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Sally Zierler, D.P.H., Associate Professor of Medical Science, Brown University School of Medicine

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The Brown University Child and Adolescent Behavior Letter (ISSN 0898-2562) is published by Manisses Communications Group, Inc., 208 Governor St., Providence, RI 02906. (401) 831-6020; fax: (401) 861-6370; e-mail: lwjackim@manisses.com. Yearly subscription rates are $167 for institutions and $117 for individuals. Periodicals postage at Providence, RI. POSTMASTER: Send address changes to: Manisses Communications Group, Inc., P.O. Box 9758, Providence, RI 02940-9758. ©1998 by Manisses Communications Group, Inc. Member, Newsletter Publishers Association. **The Brown University Child and Adolescent Behavior Letter** reports monthly on work in child development. Our purpose is to provide timely, accurate information by drawing on professional journals, expert opinion and the experience of our editors and guest writers. **The Brown University Child and Adolescent Behavior Letter** does not offer medical, legal or administrative services and we encourage subscribers to seek advice from qualified professionals. **The Brown University Child and Adolescent Behavior Letter** is available in reference systems produced by Information Access Company. For more information, contact Information Access Company, Rights & Permissions Dept., 362 Lakeside Drive, Foster City, CA 94404, or call (800) 227-8431 (U.S. only) or (415) 378-5000. All rights reserved. Reproduction forbidden without the consent of the publisher. Authorization to photocopy articles for internal or personal use or the internal or personal use of specific clients, is granted by Manisses Communications Group provided that the fee of $6.00 per article is paid to the Copyright Clearance Center, 222 Rosewood Drive, Danvers, MA 01923, (508) 750-8400.

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Keep Your Eye On

... dropping birth rates.

Male birth rates are falling, according to Devra Lee Davis, Ph.D., of the World Resources Institute in Washington, D.C. When analyzing recent surveys that have looked at trends in sex ratios and congenital male reproductive problems in several countries, Davis found a broad drop in male birth rates and increasing reproductive defects. Davis believes the reasons for the drop may be biological, particularly a disruption of normal male fetal development by environmental agents such as dioxin. It is postulated that female fetuses may not be as susceptible to such factors. (*Science News*, April 4, 1998. For more information, contact Dr. Davis at World Resources Institute, 1709 New York Ave. NW, Suite 700, Washington, DC 20006.)

... diet drugs.

More than 100 children were given the controversial diet drug fenfluramine (Pondimin) in an effort to study its effect on brain activity and aggression. Advocacy groups have filed complaints alleging that two New York City hospitals violated federal research regulations because the studies provided no medical benefits to the children. The children, who were boys ages six to 11, were given fenfluramine before the popular diet drug combination known as "fen-phen" was pulled off the market last year. Fen-phen is a combination of fenfluramine and phentermine (Adipex), which the Food and Drug Administration banned because of possible links to heart valvular disease. The boys were given a single dose of up to 10 mg of fenfluramine to determine if it would raise serotonin levels in the brain and reduce aggression. (*Associated Press*, April 14, 1998)

Coming Up

A conference on **Learning Without Limits: Exploring the Intelligence of Play** will be held Aug. 21-23 at the Monterey (Calif.) Conference Center, especially targeted for parents, coaches, players and teachers. Among the featured speakers will be Joseph Chilton Pearce, author of *The Magical Child* and *Evolution's End* and internationally recognized for his vision on human development and learning; O. Fred Donaldson, Ph.D., author of the Pulitzer Prize-nominated book *Playing by Heart* and an authority on play behavior in animals and humans; Stuart Brown, M.D., a violence researcher who studied the Texas Tower Sniper and an advocate of play as a deterrent to violence; James Prescott, Ph.D., a developmental neuropsychologist lecturing on "nurturing, play and early brain development"; Chuck Hogan, renowned golf professional and sportsman, talking about *The Magical Athlete*; and others, including Lewis P. Lipsitt, Ph.D., child psychologist and editor of *The Brown University Child and Adolescent Behavior Letter*. For more information, call (562) 426-2627; fax (562) 427-8189; or e-mail ttfuture@aol.com.

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What's New in Research

Children with anxiety may benefit from SSRIs

Of the four selective serotonin reuptake inhibitor (SSRI) antidepressants — fluoxetine (Prozac), fluvoxamine (Luvox), paroxetine (Paxil) and sertraline (Zoloft) — only two, fluvoxamine and sertraline, are approved for use in pediatric patients with obsessive-compulsive disorder. The only placebo-controlled studies that have been done to date with the SSRIs in pediatric patients have been conducted in youths with OCD — not with other anxiety disorders.

However, results from clinical trials of SSRI antidepressants in children and adolescents with anxiety disorders indicate they are "safe, usually well-tolerated and may provide salutary effects for these patients," according to the authors of a recent literature review. They conclude that more research is needed to determine the safety of SSRIs to treat anxiety disorders in children.

Findling RL, McNamara JK. SSRIs in children and adolescents with anxiety disorder. *International Drug Therapy Newsletter* 1998; 33:9-11. For reprints, contact Frank J. Ayd Jr., M.D., Ayd Medical Communications, Division of the Ayd Corporation, 1130 E. Cold Spring Lane, Baltimore, MD 21239.

Baclofen brings on serious side effects

A group of adolescents became symptomatic after taking baclofen (Lioresal), a muscle-relaxant drug used to control spasticity in multiple sclerosis and spinal cord disorders. The drug was taken at a party at a suburban boy's club. The children took from three to 30 tablets (20 mg) of the drug. Chaperones who noticed that the youths became very lethargic called paramedics. After the chaperones located some of the pills and called a poison control center, the tablets were identified. Fourteen patients were taken to hospitals, and nine required intubation.

Of eight patients seen at the University of Cincinnati, the most common clinical findings were coma (seven patients), hypothermia (six patients), bradycardia (five patients), hypertension (four patients) and hyporeflexia (all patients).

The average length of time patients required mechanical ventilation was 40 hours. Three patients had cardiac arrhythmias, and two had seizures. A single dose of activated charcoal was given to all patients, as well as drugs such as nifedipine (Adalat, Procardia) for hypertension and naloxone (Narcan) for reversing the effects of baclofen. All patients recovered and were discharged within five days.

"Baclofen overdose may result in coma, apnea [halt in breathing], autonomic disturbances, cardiac

Resources

Adolescent health organization offers policy recommendations

The National Adolescent Health Information Center (NAHIC) in San Francisco has compiled policy recommendations from 36 major studies, reports and books to highlight areas where a common agenda can be developed, and to clarify the necessary steps to improve adolescent health. The recommendations include future directions for developing policy action, establishing priorities and mobilizing the public and private sectors for support.

For a summary or full report, titled "Improving Adolescent Health: An Analysis and Synthesis of Health Policy Recommendations," contact the NAHIC at 1388 Sutter St., Suite 605A, San Francisco, CA 94109; phone (415) 502-4856. The e-mail address is nahic@itsa.ucsf.edu.

At-risk catalog features 'homework hotline'

The Bureau for At-Risk Youth in Plainview, N.Y., has a new "Homework Hotline Educational Services" voice messaging system for public and private schools in the United States. The systems allow schools to create voice mailboxes for teachers and administrators so that parents can access a teacher's mailbox 24 hours a day, seven days a week, to hear prerecorded messages about homework assignments, daily activities, special events and even absences.

The systems are installed in almost 600 schools nationwide. They have been shown to improve parental involvement, school-parent communications, academic achievement, behavior problems and daily attendance.

For more information, contact Donald Fujihira at The Bureau for At-Risk Youth, 135 Dupont St., Plainview, NY 11803-0760; phone (800) 999-6884.

conduction abnormalities and seizures," the authors say. Without treatment, many of the children would have died, they add. They emphasize the importance of educating youth about the dangers of experimenting with any drug for recreational purposes.

Perry HE, Wright RO, Shannon MW, et al.: Baclofen overdose: Drug experimentation in a group of adolescents. *Pediatrics* 1998; 101:1045-1048. For reprints, contact Holly E. Perry, Ph.D., Department of Pediatrics, University of Cincinnati College of Medicine, 231 Bethesda Ave., Cincinnati, OH 45267.

Television-watching is associated with obesity

Intervention strategies to promote lifelong physical activity among U.S. children are needed to stem the adverse health consequences of inactivity, such as obesity, according to the findings of a recent study.

Researchers conducted a study to assess participation in vigorous activity and television-watching habits and their relationship to body weight in U.S. children. The study was a nationally representative cross-sectional survey that included an in-person interview and medical examination.

Between 1988 and 1994, 4,063 children ages eight to 16 were studied. Mexican-Americans and non-Hispanic blacks were oversampled to produce reliable estimates in those groups.

The children were measured for episodes of weekly vigorous activity and daily hours of television watched, and their relationship to body mass index and body fatness.

Eighty percent of the children reported three or more bouts of vigorous activity each week, although the rates was lower in non-Hispanic black and Mexican-American girls (69 percent and 73 percent, respectively). Twenty percent of children participated in vigorous activity twice or fewer times each week, and this rate was higher in girls (26 percent) than in boys (17 percent).

Overall, 26 percent of U.S. children watched four or more hours of television per day and 67 percent watched at least two hours of television per day. The highest rates of television-watching occurred among non-Hispanic black children (42 percent), who watched four or more hours of television per day.

Not surprisingly, boys and girls who watched four or more hours of television each day had greater body fat and greater body mass index levels than did children who watched less than two hours of television a day.

"Many U.S. children watch a great deal of television and are inadequately vigorously active," the authors conclude. "Vigorous activity levels are lowest among girls, non-Hispanic blacks and Mexican-Americans."

Andersen RE, Crespo CJ, Bartlett SJ, et al.: Relationship of physical activity and television watching with body weight and level of fatness among children. *Journal of the American Medical Association* 1998; 279:938-942. For reprints, contact Ross E. Andersen, Ph.D., Johns Hopkins School of Medicine, 333 Cassell Drive, Suite 1640, Baltimore, MD 21124.

Recommended Reading

RELUCTANT WITNESSES: CHILDREN'S VOICES FROM THE CIVIL WAR — *E.E. Werner. Boulder, Colo.: Westview Press. 175 pages, $24 (hardcover), 1998. (800) 386-5656.*

Famous developmental psychiatrist Emmy Werner, author of classic scholarly works on vulnerability and resilience in development, has done it again. Here she applies her eye for developmental processes, and problems of children growing up, to understand the diaries, letters and reminiscences of 120 children, ages 4 to 16 years, who tell of their hardships and how they managed to cope.

BEHAVIORAL MEDICINE AND WOMEN: A COMPREHENSIVE HANDBOOK — *E.A. Blechman and K.D. Brownell, Eds. New York: Guilford Publications Inc. 876 pages, $75 (hardcover), 1998. (800) 365-7006.*

An authoritative compendium based upon numerous experts' summaries. Features of the volume include sections on asthma; abortion; the endocrine system; immunity; HIV infection; stress; culture and women's health; anxiety; rape and post-traumatic stress; lesbian health; and panic disorder. A very useful book.

RETHINKING INNATENESS: A CONNECTIONIST PERSPECTIVE ON DEVELOPMENT — *J.L. Elman, E.A. Bates, M.H. Johnson, A. Karmiloff-Smith, D. Parisi and K. Plunkett. Cambridge, Mass.: MIT Press. 447 pages, $40 (hardcover), $17.50 (softcover), 1996. (800) 356-0343.*

This scholarly treatise relates to the well-argued issue of whether and to what extent certain behaviors, such as language performance, are innate. The contributors to this volume do some rethinking, as the title suggests, and move themselves around on the matter of heredity-environment. It's intense and interesting reading.

An optimistic look at the nature-nurture controversy

By Julius Segal, Ph.D.

What determines your child's personality? Over the years, explanations have swung like a pendulum from "nature" (heredity is responsible) to "nurture" (upbringing is all that matters) and back again. The truth is that neither extreme is valid. Researchers studying genetics and psychology believe that both play a role in the development of children's personalities. The real question is no longer whether the human personality has innate or environmental roots, but how the two relate.

At the instant of conception, the chance combination of mother's and father's genes produces a unique human being, nowhere duplicated. Each new baby has distinct physical, personality and behavioral characteristics. Your child (unless you have identical twins) is unique at birth. Genes influence how vulnerable children are to stress, how motivated they become to achieve, their leadership skills, their career interests and their hobbies.

If you already have more than one child, or if you have friends with children, you are probably not surprised by this. Many parents notice differences between their children as newborns. Some are constantly squirming, others are in repose; some are sensitive to every sound, others respond little. In the early years, the contrasts in temperament between children become even more apparent.

However, despite the important influences of genes, it is clear that nature cannot account for all of children's personality differences. Indeed, in any group of children the variations found in any given personality trait are due at least as much to environment as to heredity.

That influence begins in the womb, where the physical connection between the fetus and the mother creates the baby's first environment. During pregnancy, the mother's diet helps determine whether the baby will have difficulty attaining the IQ level that its genes might otherwise have made possible. Mothers who smoke constantly, use drugs or drink heavily deprive the baby of oxygen and nutrients. This can affect the baby's later intellectual and emotional development.

Then, from the moment of birth, environmental factors begin to exert even greater power. Your baby's interactions with you and other family members shape your child's motives and values. You influence the way your children decide to deal with conflicts. Later, people and experiences outside the family affect their development.

Continued, over ...

Most researchers today believe genes do not determine exact personality traits, but rather a range over which the trait may evolve. For example, a child's genes may indicate average to above average intelligence. You can safely say that this child will not develop the super-IQ of a genius. Yet, you cannot predict what the IQ will be within the expected range.

The exact IQ will depend on parents, education and other external factors. So, you still can encourage your children to achieve to the best of their abilities by reading together, playing stimulating games together, etc.

If your child seems "naturally insecure" or shy, you can instill confidence by missing no opportunity to offer praise. This will boost your child's self-esteem. A charismatic teacher can ignite a passion for science in a child labeled "born lazy" by others. On the flip side, however, constant criticism can deflate a child's self-confidence. Genes represent influences and potentials, not strict blueprints for behavior.

For these reasons, it would be very difficult for you to predict, from the way your children behave at the start, how they will behave later on. Even given the strength of genetic traits, no one can be at all certain at any given moment what twists and turns development will take in the months and years ahead. The years between infancy and adulthood will be full of unforeseen events — and these are likely to bring gratifying changes in the patterns of personality dictated at the start by nature. "Human development," says Harvard University developmental psychologist Jerome Kagan, Ph.D., "does not proceed along a single, predictable line. Instead, it is comprised of a set of transitions and transformations that can advance in many different directions — more like a branching oak tree than a tall, slim palm."

Dr. Julius Segal was for many years director of public information for the National Institute of Mental Health in Bethesda, Md. A noted writer of popular articles on child development and behavior, he co-authored a successful and influential textbook on child psychology with Prof. Jerome Kagan of Harvard University. Dr. Segal was a fellow of the Stanford Center for the Advanced Study of Behavior.

The Brown University **Child and Adolescent Behavior Letter**

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PLACE YOUR BUSINESS CARD HERE BEFORE PHOTOCOPYING

Self-esteem
from page 1

understanding in developmental psychology, pediatric psychiatry, learning and education. It also is possible now to examine the implications of these findings about the development of competence and coping skills in early life for the health and well-being of individuals and populations in adult life.

Forming the connections

A key part of the story from research in developmental neurobiology is how the nerve cells differentiate and form their connections. The brain consists of billions of neurons that must differentiate in early life for their different roles and form the complex network of connections that are key for the functioning of an individual. At birth, the brain has established only the initial connections and paths among its billions of neurons. The neural activity that stimulates differentiation and creates the complex nerve circuits that are key for optimum functioning is driven by the flood of sensory experiences a child receives and that are transmitted to the neurons in the brain.

A critical period for the development of core functions such as arousal, behavior and emotion occurs during the first few years of life. Neglecting or abusing an infant during this critical period can produce functions and wiring patterns in the core of the brain that can lead to heightened anxiety in response to stimuli, and to stress leading to abnormal adverse behavioral responses in childhood and adult life.

So, the adult interaction with a child during this sensitive early period provides stimuli that will influence how the brain develops and how children respond to new situations and challenges. Children who are abused (physically or sexually) early in life, or are in abusive family environments, are at risk in the development of the core functions of the brain that are exquisitely sensitive to danger or challenges, for example.

This puts the nature/nurture debate into a different perspective. We now know why nurturing does have a substantial effect on behavior, IQ, competence and coping skills.

The brain wires itself through the formation of quadrillions of connections among the billions of neurons. The number of genes in cells are far too few to determine this process. (There are about 100,000 genes in each of us but quadrillions of connections that develop in the brain.) The formation of the connections is driven by the stimulation the brain receives during these sensitive periods. Although genetics determines the core architecture, it is the sensory stimulation that drives the development and differentiation for the fully functioning brain. This puts the nature/nurture debate into a different perspective. We now know why nurturing does have a substantial effect on behavior, IQ, competence and coping skills.

The link to education

There are implications that come from this work that link closely to the observations from developmental psychology and education. Children who have an adverse early childhood can have difficulty in coping with the school system when they enter kindergarten, because of deficits in cognition and behavior. Boys who cannot cope show antisocial behavior at this stage and tend to do poorly in school, and those with violent tendencies can be disruptive of the school system. As many as 25 percent of boys identified as antisocial when they enter kindergarten are delinquent by age 13.

Although supportive interventions in the school period can turn some of these problems around, the effect is limited. But there is now substantial evidence that early interventions that enhance the quality of stimulation for children in difficult circumstances can substantially reduce behavioral problems when these children enter the school system, and enhance their learning capacity, coping skills and competence.

In one study, children who were given good early-childhood support (a quality form of preschool education) between the ages of three and six had far better competence and coping skills by the age of 27 than a control group who did not receive the intervention between ages three

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and six. The adults who had the early intervention completed more schooling; had far fewer criminal problems, including substantially less drug use; had jobs; were married with families; and had far fewer mental health problems. It has been estimated that for every dollar this intervention program costs, the return after more than 20 years is at least seven dollars. An even earlier intervention for children in difficult circumstances would probably have an even greater effect.

Recent evidence indicates that cognitive ability as well as behavior is strongly influenced by the quality of the stimulation children receive in these early years. A study in North Carolina showed early intervention that provided good stimulation through appropriate interaction with the children improved the IQ of the children who were given the intervention before they entered the school system. Key cognitive functions in mathematics are acquired between the ages of four and seven. A preschool mathematics program has been found to create superior achievement for a group of children in a poor environment when compared to a control group in similar socioeconomic circumstances not given the intervention program. The children given the intervention program actually did better than students from a middle-class background in a magnet school. Recent observations indicate that the quality of early interaction with children also influences literacy.

Intervene before age 10

The brain's great spurt draws to a close around the age of 10. By this time, the brain will have destroyed the weakest connections, preserving only those that have been well-established by experience. While the value of stimulation has been recognized for some time, it is only now that this can be quantified and explained through the hard evidence from today's research in neuroscience.

When is it too late to repair the damage caused by emotional or physical abuse or neglect? That is a critical question that comes from this new knowledge.

During these early years the brain is very plastic. If a child is provided with better circumstances during these early years, there will be considerable improvement that can be reinforced when the child enters the school system. However, the ability to rebound decreases as the child becomes older. In the early years there are a number of sensitive or critical periods when the brain needs certain types of sensory input to establish and stabilize important long-lasting structures.

Good affordable day care (mainly good support for parents, particularly mothers and their children) or early-childhood education for all sectors of society is key for a future learning society. All evidence indicates that the competence and coping skills of a population in childhood and adult life is a gradient when assessed against socioeconomic markers such as income and education. This means that the biggest part of the problem is in the middle-class population, although the largest proportions affected will be the children in poverty. ■

Max Cynader, Ph.D., is a fellow of the Canadian Institute for Advanced Research Human Development Program and a member of the department of ophthalmology at the University of British Columbia.

Fraser Mustard, M.D., is a Bell Canada Fellow and founding president of the Canadian Institute for Advanced Research.

This article was adapted with permission from *Entropy*, the Founders' Network Report in support of The Canadian Institute for Advanced Research. For more information, contact Dorothy McKinnon at (416) 593-5999.

Self-mutilation

from page 1

20 without body modification. The two groups were matched for age and sex. The average age of the participants was 21, and most were age 25 and younger. All tattooing and body piercing were rated by total number, location and theme.

"So somebody who had a flower [tattoo] would be [rated] a one, but somebody who had a skull and crossbones or some message about death would get a five," he explains. "We did the same thing with the body piercing. [A rating of] one would be somebody who had pierced the cartilage at the top part of the ear. Somebody with [a rating of] five would have pierced part of [his or her] genitalia."

Ceniceros says one boy in the study had five pierced areas on his genitalia, including a ring that went through his urethra. His body piercing score was 25.

"The scoring had to do with the intrusiveness of where the [piercing] was," he says.

Ceniceros says the more body piercings or tattoos patients had, the more likely they were to practice self-mutilation, have a criminal record, have sex with multiple partners without practicing safe

sex and play Russian roulette.

"They take a revolver, put one bullet in the chamber that holds six bullets, and then spin the chamber," he explains. "Then they put [the gun] to their head and pull the trigger. So they have a one in six chance of killing themselves. A very high number of people who did that had body piercing and tattoos."

Anxiety correlated with body modification

Although patients with tattooing and body piercing reported no more depressive symptoms than patients without body modifications, they did report significantly higher anxiety symptoms.

"If you look at the literature on self-mutilation, it's thought that self-mutilating behavior is an actual anxiolytic — a way to soothe the anxiety you feel," says Ceniceros.

Although there is no definitive explanation for using self-mutilation to ease anxiety, Ceniceros notes that one theory maintains that self-inflicted physical pain actually releases endorphins in the brain. Endorphins are neurochemicals that have been called the body's own form of opium because of their ability to elevate mood, says Ceniceros.

"It's the same thing that is released when people receive acupuncture," he explains. "The endorphins calm them down. So the more you mutilate, the more of the chemical you get, and the more you calm down."

Another dramatic finding in the study was that all the women who had tattoos or body piercing had eating disorders. "There's some literature that says that eating disorders are a form of self-mutilation also," Ceniceros explains. In addition, he says there was no significant difference between males and females in the study, and that they tended to practice similar self-mutilating behaviors.

Results applicable to general population

Because all the patients in the study were inpatients at a psychiatric hospital, can the results be applied to the general public? Yes, Ceniceros says. Clearly, peer pressure is a factor for adolescents and teens who undergo tattooing or body piercing, and not all youth who undergo body modification have psychiatric disorders. In fact, tattooing and body piercing aren't considered unusual, and have become mainstream practices in recent years.

"The endorphins calm them down. So the more you mutilate, the more of the chemical you get, and the more you calm down."

Salvador Ceniceros, M.D.

"Some kids are going to do it just because it's the thing to do," says Ceniceros. "But where it can become problematic is when you see kids who do it and who continue doing it. In other words, they're not satisfied with one piercing, but they have multiple piercings. They don't have one tattoo, they have multiple tattoos. They aren't satisfied with having a professional do it — they start doing it themselves."

The location of the tattoo or body piercing also should be considered, he adds. If someone has a small butterfly that is hidden under clothing, "That's a lot different than someone who has a tattoo related to killing or dying on their upper arm." A pierced nose or navel — which have become very trendy body parts to have pierced in recent years — appear to be less indicative of psychiatric problems than pierced tongues or genitals do, for example.

Ask patients about motives

Ceniceros recommends that mental health professionals who see patients with tattooing or body piercing ask them why they had tattooing or body piercing done in the first place. If patients answer with a response such as "because it felt good," that should send up a red flag that there is underlying anxiety or other psychiatric conditions, he Ceniceros.

He says he plans to conduct a more in-depth study of body piercing and tattooing in a younger age group of patients ranging from 12 to 18 years old. Another study in the outpatient setting is planned as well.

"The most important message of this [current] study is that if you see a kid who is doing this kind of behavior — especially if they're doing it to themselves or a friend is doing it to them — they need to be carefully screened for other kinds of problems," Ceniceros adds. "I think this is a real important marker that isn't looked at enough." ■

Reported by Theresa Waldron, a freelance reporter based in Marietta, Ga.

To get a referral to a local program dealing with self-abuse and self-mutilation, call (800) 366-8288. This number is administered by the Hartgrove Hospital Program.

Guest Commentary

Being an effective parent requires making the time to do so

By Dwight B. Heath, Ph.D.

Many parents say they are frustrated because their children are increasingly cool to them, distant, interested in other things and more influenced by television, peer pressure and other forces over which the parents have no control. It can be a frightening as well as a disappointing experience, as one feels ever more helpless to provide the support, guidance and example that they think of as a parent's proper role.

And yet we all know how difficult it is to fulfill that complex and demanding role, especially when it seems as if there just isn't time enough for any of us to do what we want to do. One first step, simple in concept but not so easy to do, is to make some time for parenting. The days and weeks are no shorter than they've ever been, but a proliferation of assorted commitments often makes them seem so. Those who have had to take another job to make ends meet, or families where both parents work because one breadwinner is not enough, do have special problems. So does anyone trying to juggle the conflicting demands of single parenthood. But almost anyone can — if they really believe it is important enough — set aside half an hour a day, or half a day each week, to spend with the younger generation. Think of it as a cheap but invaluable investment.

I'm not talking about anything abstruse or theoretical, but just about talking with one's kids. In the absence of that, is it any wonder they turn to other sources?

People sometimes wonder why it is that peer pressure and advertising seem to have so much impact on young people. Too often it's simply because there's a lack of other influences that might let them know alternative ways of looking at or thinking about things.

Families used to sit down to eat dinner together, sometimes talking about what happened during the day, sometimes discussing the evening news. In a small community, such exchanges often helped young people understand the informal social structure within the circle of kin and beyond, and the rights and obligations that go along with such relationships. Without lecturing or preaching, anecdotal accounts of everyday living can serve to illustrate how things get done — and how sometimes they don't — with the logic and reasons couched in terms that everyone can understand. Looking at national or international affairs can help young people better understand forces and contexts that, in the abstract, might seem to be remote but that impinge on them in ways that can easily be demonstrated and explained. Talking about one's work can do much to dispel the mystery of the disconnect between home and job, or to explain why some desired purchase may have to be deferred. Talking about food can range from nutrition to agriculture, from ecology to labor relations, from geography to economics.

If this sounds like romantic nostalgia straight out of a Norman Rockwell painting, consider that this is the way most of the world learns how to cope with being a member of society — now, as they have throughout history. The human animal is distinctive in large part precisely because so little of what we know and do is instinctive or inborn, and because so long a period of maturation is devoted to inculcating ready-made answers to big questions and solutions to common problems. Some social scientists talk about "socialization" and others prefer to call it "acculturation," but in both instances they are referring to the long and massive process by which some of the norms, values, attitudes and understandings of one generation are passed to those of the next. In the fullest sense, it's education — but that's too often thought of as occurring only in the classroom.

I'm not talking about anything abstruse or theoretical, but just about talking with one's kids. In the absence of that, is it any wonder they turn to other sources?

And no parent need feel constrained to have a ready-made list of topics or themes that have to be discussed. Spending time together is the surest way to get one's child to communicate in ways that may surprise — and should delight — any parent. To listen and to respond — in an honest and engaged manner — is probably the best reward that one can give another person, no matter what their age. ■

Dwight B. Heath is a professor emeritus of anthropology at Brown University and a contributing editor to *The Brown University Child and Adolescent Behavior Letter*.

ISSN 0898-2562

The Brown University Child and Adolescent Behavior Letter

Providing the link between behavioral research and your clinical work.

Special 10-Page Report: Child Abuse

Child maltreatment prevention programs are still largely ineffective, after 30 years of research

by Richard J. Gelles, Ph.D.

Over the past 30 years, child maltreatment has been transformed from an issue obscured by selective inattention to a problem that receives increasing professional, public and policy attention. The explosive growth in our knowledge and understanding of the various aspects and facets of child maltreatment has produced a wealth of information about the extent, patterns and consequences of maltreatment.

However, our knowledge about the effectiveness of efforts to treat and prevent the abuse and neglect of children has lagged far behind other research efforts in this field. Using the normal standards for evaluation research to judge the effectiveness of treatments for abuse and neglect, we answer the question "What works?" with either, "We don't know" or "Most interventions are not very effective."

Studies found that home health visiting programs, such as "Healthy Families," were the most effective intervention efforts.

Home visits help

The National Academy of Sciences convened two panels to examine child abuse and neglect. The first panel's report, *Understanding Child Abuse and Neglect* (1993), stated that the fragmentary nature of research on prevention and treatment inhibited the panel's ability to evaluate the

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Vol. 14, No. 8 August 1998

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Child abuse documentation has improved little since 1980.
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This month's client handout:
When you need help ...

First Person

Being objective, keeping boundaries requires much advance preparation

By Ronald L. Simmons, Ph.D.

As mental health professionals, we all routinely see heartbreaking cases — families torn apart by extramarital affairs, substance abuse, child abuse, domestic violence and divorce. It is hard to remain objective in these situations. Because we are human, it is difficult to distance ourselves from our patients' issues. However, we are trained to be ethical and professional, and we owe it to our patients to maintain appropriate boundaries while helping them through their crises. Finding a happy medium between empathy and objectivity is an important part of being a good psychotherapist.

As a licensed psychologist working with families in a rural setting, I often see children and adolescents who have been abused and neglected. I recently provided therapy to a 12-year-old boy who had been removed from his mother's home by the local Department of Family and Children's Services (DFCS). Although there was no clear evidence that allegations of physical abuse were true, the boy was

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Editor: Lewis P. Lipsitt, Ph.D.
Professor Emeritus of Psychology, Medical Science, and Human Development at Brown University

Contributing Editors:

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Cynthia Garcia Coll, Ph.D., Professor, Education, Psychology and Pediatrics, Chair of Education Department, Brown University

Ferdinand Jones, Ph.D., Professor of Psychology, Brown University, formerly director of Brown University Student Counseling

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The Brown University Child and Adolescent Behavior Letter (ISSN 0898-2562) is published by Manisses Communications Group, Inc., 208 Governor St., Providence, RI 02906, (401) 831-6020, fax: (401) 861-6370, e-mail: lwjackim@manisses.com. Yearly subscription rates are $167 for institutions and $117 for individuals. Periodicals postage at Providence, RI. POSTMASTER: Send address changes to: Manisses Communications Group, Inc., P.O. Box 9758, Providence, RI 02940-9758. ©1998 by Manisses Communications Group, Inc. Member, Newsletter Publishers Association. **The Brown University Child and Adolescent Behavior Letter** reports monthly on work in child development. Our purpose is to provide timely, accurate information by drawing on professional journals, expert opinion and the experience of our editors and guest writers. The **Brown University Child and Adolescent Behavior Letter** does not offer medical, legal or administrative services and we encourage subscribers to seek advice from qualified professionals. **The Brown University Child and Adolescent Behavior Letter** is available in reference systems produced by Information Access Company. For more information, contact Information Access Company, Rights & Permissions Dept., 362 Lakeside Drive, Foster City, CA 94404, or call (800) 227-8431 (U.S. only) or (415) 378-5000. All rights reserved. Reproduction forbidden without the consent of the publisher. Authorization to photocopy articles for internal or personal use or the internal or personal use of specific clients, is granted by Manisses Communications Group provided that the fee of $6.00 per article is paid to the Copyright Clearance Center, 222 Rosewood Drive, Danvers, MA 01923, (508) 750-8400.

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Printed in USA

Psychological maltreatment is not an ancillary issue

By James Garbarino, Ph.D.

When children are psychologically abused, their development of self-esteem, of social competence, of the capacity for intimacy, and for positive and healthy interpersonal relationships, is jeopardized. We know this in a personal sense. We know that they and their families need help. But what exactly is psychological maltreatment?

Any observation of psychological abuse depends heavily on the social and cultural context in which it takes place. Psychologically abusive behavior conveys a culture-specific message of rejection or impairs a culturally valued psychological process, such as the development of a coherent positive self-concept. When families or societies sabotage this process of establishing a strong ego, when they send destructive messages to children, we enter the realm of psychological maltreatment.

We need the perceptual filter of culture to understand psychological abuse. We must accommodate cultural and ethnic differences when defining such maltreatment. For example, in some cultures it is normal for children to sleep with parents. In others, such arrangements verge on the pathological. Conversely, some cultures consider it abusive to require that infants sleep apart from parents. Some such differences are simply a matter of style; others reflect alternative but equivalent socialization goals. Still others reflect real pathology because they violate a set of categories general enough to reflect the universals of human nature.

Culture is not the only accommodation, however. If we are to move to an operational definition of psychological maltreatment, we must take into account a developmental perspective on the meaning and significance of behavior. Clearly, what psychological maltreatment is for young children may not be such for adolescents and vice versa. For example, scaring with tales of ghosts and monsters is a genuine threat to most young children but to very few adolescents. However, teenagers are sensitive to peer humiliation while infants are not.

Developmental Issues

We may need age- or stage-specific definitions to the same extent that we do in assessing social competence and other developmental phenomena. This issue blends with that of assessing severity. Are developmentally advanced children more resistant to some forms of psychological maltreatment but more vulnerable to others? For example, are cognitively sophisticated children more vulnerable to subtle insult than unsophisticated children? Are infants more vulnerable to being ignored than adolescents? We must work out these questions.

The very "problem" that the socioemotional consequences of

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acts largely define the acts themselves turns psychological maltreatment into the central issue in most child welfare considerations. Preserving a child's physical health is vital, of course. It is a necessary precondition for child welfare to exist. Once physical survival is assured, however, the subjective reality of child development is the primary concern. How do children think and feel about their world? How do they define the treatment they receive at the hands of their parents and guardians?

The core issue is identity and the development of self, in the sense of ego strength, self-concept and social competence.

We must approach this issue developmentally. The vulnerability of children shifts as cognitive, linguistic and affective capacities emerge. A baby responds mainly to voice tone, for example, while a teenager can comprehend the terrifying paradox of the double bind. The infant's pre-programmed need for developing attachment makes the aloof parent a serious threat while the adolescent's impulse to conformity makes threats of public humiliation particularly powerful as a form of abuse.

Central issue

Rather than casting psychological maltreatment as an ancillary issue, subordinate to other forms of abuse and neglect, we should place it as the centerpiece of efforts to understand family functioning and to protect children. In almost all cases, the psychological consequences of an act define that act as abusive. This is true of physical abuse — an injury inflicted by a parent in rage is different from the same "injury" inflicted by accident in the course of an athletic event. It is also true of sexual abuse, since sexual acts have little or no intrinsic meaning apart from their social psychological connotations — as the incredible variety of norms regarding sexual activity in childhood and adolescence across cultures suggests. However, rarely, if ever, does a child experience physical abuse or neglect, or sexual assault of exploitation in a relationship that is positive and nurturing. Indeed, even to pose the matter in such terms seems ridiculous.

The five manifestations

Psychological maltreatment, then, is a concerted attack by an adult on a child's development of self and social competence, a pattern of destructive behavior, and it takes five forms:

- **Rejecting** — the adult refuses to acknowledge the child's worth and the legitimacy of the child's needs.
- **Isolating** — the adult cuts off normal social experiences, pre-

Definitions of child maltreatment

The legal definitions of terms related to the maltreatment of children vary from state to state. Clinicians should be aware of the definitions used in their own locale. Broadly speaking:

Neglect is the willful failure to provide adequate care and protection for children. Physical neglect may involve failure to feed the child adequately, failure to provide medical care or failure to protect the child from danger.

Physical abuse is the infliction of injury by a caretaker. It may take the form of beating, punching, kicking, biting or other methods. The abuse can result in injuries such as broken bones, internal hemorrhages, bruises, burns and poisoning. It is important to consider cultural factors in assessing whether the discipline of a child is abusive.

Sexual abuse of children refers to sexual behavior between a child and an adult or between two children when one of them is significantly older or uses coercion. The perpetrator and the victim may be of the same sex or the opposite sex. The sexual behaviors include touching breasts, buttocks and genitals, whether the victim is dressed or undressed; exhibitionism; fellatio; cunnilingus; and penetration of the vagina or anus with sexual organs or with objects. Pornographic photography is usually included in the definition of sexual abuse. It is important to consider developmental factors in assessing whether sexual behaviors between two children are abusive or normative.

Psychological abuse occurs when a person conveys to a child that he or she is worthless, flawed, unloved, unwanted or endangered. The perpetrator may spurn, terrorize, isolate or berate the child. Psychological abuse also may be caused by repeatedly taking a child for unnecessary medical treatment. When psychological abuse is severe, it is often accompanied by neglect, physical abuse and/or sexual abuse.

Journal of American Child and Adolescent Psychiatry 1997; 36(3):424-425.

vents the child from forming friendships and makes the child believe that he or she is alone in the world.

- **Ignoring** — the adult is psychologically unavailable, perhaps being physically present but not being responsive to the child's need for interaction.
- **Terrorizing** — the adult assaults the child with words, creates a climate of fear, bullies and frightens the child and makes the child believe that the world is capricious and hostile.
- **Corrupting**— the adult "misocializes" the child, stimulates the child to engage in destructive behavior, reinforces that deviance and makes the child unfit for normal social experience.

These are basic threats to human development. Psychological maltreatment is the core issue in the broader picture of abuse and neglect. It provides the unifying theme and is the critical aspect in the overwhelming majority of what appear as physical and sexual maltreatment cases.

Whereas children can absorb and overcome the experience of physical assault and sexual misuse if they are psychologically strengthened, they rarely do so if they are psychologically mistreated as part of the experience. Mounting evidence on the beneficial impact of treating sexual abuse victims seems to verify this proposition.

The definition of psychological maltreatment as patterns of rejection, isolation, terrorizing, ignoring and/or corrupting children places psychological abuse and neglect within a broader general definition of child maltreatment: acts of omission or commission by a parent or guardian that are judged by a mixture of community values and professional expertise to predict developmental damage.

What's "appropriate?"

"Maltreatment" is thus intrinsically a social label. It is not enough that patterns of behavior are damaging; they also must violate some norm of propriety. We damage children in many ways that do not constitute maltreatment: We circumcise baby boys. We pierce the ears of little girls.

Whereas children can absorb and overcome the experience of physical assault and sexual misuse if they are psychologically strengthened, they rarely do so if they are psychologically mistreated as part of the experience.

We expose young athletes to elevated risks of physical harm. We feed children high cholesterol diets. We make children anxious about divorce, and guilty about masturbation.

These forms of damage are not yet defined as inappropriate, but definitions of "appropriate" parental action can change. For example, now that infant car seats are standard, it is considered inappropriate for a mother to travel with an infant on her lap, unlike a few years ago when car seats were optional. Similarly, paddling a child and shaking an infant were once considered "benign discipline" but now are defined as high-risk assaults. In both cases, "perpetrators" still tend to be absolved from "intent to damage" the child. But this too can change.

Conclusion

We must decide as a community how far we can go and should go in labeling parental behavior as maltreatment. In doing so, we put our definition into operation. But which is more important — community standards or professional expertise — to determine psychological maltreatment? Must such behavior meet both criteria?

To some extent, a complete answer can only come as professionals, parents and citizens work things out "in the field." But as a start, let's say that we set the limits of definition so that behavior must seriously violate one and at least moderately violate the other criterion to constitute psychological maltreatment. Neither criterion is sufficient by itself. Both are necessary. But we do recognize that the more serious the violation of one criterion, the less serious the other violation need be.

The concept of psychological maltreatment offers a vehicle for unifying and illuminating the broader topic of abuse and neglect. Such a conception anchors efforts to identify, diagnose and intervene where they belong, in the child's emergent map of the world and his or her place in it. ■

James Garbarino is co-director of the Family Life Development Center and Professor of Human Development at Cornell University. He received the first C. Henry Kempe Award from the National Conference on Child Abuse and Neglect, and is the author of 17 books on child development and family issues. Among the most recent are Understanding Abusive Families (1997) and Raising Children in a Socially Toxic Environment (1995). The family Life Development Center operates a resource center dealing with psychological maltreatment — "Just for Kids," that can be accessed via e-mail at just4kids@cornell.edu or by phone at (888) 594-5437.

When you need help....

American Bar Association
National Legal Resource Center
for Child Advocacy and Protection
40 15th St. NW
Washington, DC 20005
(202) 662-1000

Child Abuse Listening Mediation
(CALM)
P.O. Box 718
Santa Barbara, CA 93102
(805)965-2376

Children's Rights Project
404 Park Avenue S., 11th Floor
New York, NY 10016
(212) 683-2210

American Humane Association
American Association
for Protecting Children
9725 East Hampden Avenue
Denver, CO 80231
(303) 792-9900

Families Anonymous Inc.
P.O. Box 3475
Culver City, CA 90231-3475
(818) 989-7841

National Center for Child Abuse
and Neglect (NCCAN);
Children's Bureau, Administration
for Children, Youth and Families;
Office of Human Development
Services; Department of Health and
Human Services
P.O. Box 1182
Washington, DC 20013
(202) 879-4839

National Center for Juvenile Justice
701 Forbes Ave.
Pittsburgh, PA 15219
(412) 227-6950

National Council of Juvenile
and Family Court Judges
P.O. Box 8970
Reno, NV 89507
(702) 784-6012

National Council on Child Abuse
and Family Violence
1155 Connecticut Ave. NW, Suite 400
Washington, DC 20036
(202) 429-6695

National Education Association
Human and Civil Rights Unit
1201 16th St. NW
Washington, DC 20036
(202) 822-7711

National Exchange Club Foundation
for Prevention of Child Abuse
3050 Central Ave.
Toledo, OH 43606
(419) 535-3232

National Committee for the Prevention
of Child Abuse (NCPCA)
332 South Michigan Ave., Suite 1600
Chicago, IL 60604
(312) 663-3520

Parents United/Daughters and Sons
United/Adults Molested as Children
United
615 15th St.
Modesto, CA 95354
(209) 572-3446

Save the Children
National Office
54 Wilton Road
Westport, CT 06880
(203) 226-7271

SCAN (Stop Child Abuse and Neglect) Associates
1400 West Markham
Little Rock, AR 72201
(501) 372-7226

Hotlines

National Child Abuse Hotline: Childhelp, USA
(800) 422-4453

National Runaway Hotline
(800) 231-6946

National Runaway Switchboard
(800) 621-4000

Youth Crisis Hotline
(800) 448-4663

The Brown University Child and Adolescent Behavior Letter

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What's New in Research

How well is physical abuse documented in children?

Los Angeles investigators recently performed a retrospective chart review of children evaluated in the pediatric emergency department in 1980 and 1995 who were given a diagnosis of physical abuse. The unstructured pediatric emergency department form and the structured child abuse reporting form were reviewed for documentation of 20 items, including history, physical examination, diagnostic procedures and disposition. Data documented in 1980 were then compared to data for 1995.

The only significant difference concerning documentation on the unstructured pediatric emergency department form between 1980 and 1995 was better recording of Child Protective Services involvement and case disposition in the latter year. In addition, half or more of the records omitted documentation of at least one important type of information, such as witnesses to injury or past injuries. None of the records contained a developmental history. The only aspects of the structured child abuse reporting form that improved between 1980 and 1995 were time of arrival to the emergency department and illustrations of injuries.

The researchers conclude that there was "little improvement in physician documentation of child physical abuse" between the two time periods, even though the hospital had increased its house staff education of child abuse between those intervals. They recommend more intensive physician education on child abuse, particularly regarding documentation of injuries.

Limbos MAP, Berkowitz CD: Documentation of child physical abuse: How far have we come? *Pediatrics* 1998; 102:53-58. For reprints, contact Mary Ann P. Limbos, M.D., Division of General and Emergency Pediatrics, Harbor-UCLA Medical Center, 1000 West Carson St., Torrance, CA 90509.

Keep Your Eye On

... school threats.

Police and school officials are taking seriously all threats made by youth against schools since the recent series of attacks by students against other students. The most recent such attack occurred in Springfield, Ore., when 15-year-old Kip Kinkel allegedly opened fire in a high-school cafeteria, killing or injuring 24 students.

Since the attacks, a string of copycat threats have been made across the country. A 14-year-old eighth-grader in Connecticut and a 15-year-old high school freshman in New Jersey have been charged with making violent threats against classmates and teachers. Similar problems have occurred in New York, Delaware, West Virginia, Kansas and other states. When authorities are notified of such incidences, they arrest the youths for making terroristic threats. Students' homes are searched, and in some cases, youths have been jailed when bombs or illegal firearms were confiscated. (*Associated Press*)

... self-defense.

Ninth-grade girls in a Pennsylvania school are learning self-defense to help them develop self-assurance and defend themselves when threatened by an attacker. Jean Lombardi, physical education teacher at Franklin Regional Junior High School in Murraysville, Pa., teaches a three-week course to the girls. She says she helps them learn confidence first so they may never have to resort to physical means. Lombardi says

Health care business information available on the Internet

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she teaches the students to run first, if they can. If that doesn't work, she teaches them to try to talk their way out of an attack. Third, she teaches them to try to distract the attacker and run. If all those tactics fail, she instructs the girls to fight by kicking and punching their attacker. (*School Board News*, May 26, 1998) For more information, contact Jean Lombardi, Franklin Regional Junior High School, 4660 Old William Penn Highway, Murraysville, PA 15668. Telephone: 724-327-5250.

Recommended Reading

SAVING OUR CHILDREN FROM POVERTY: WHAT THE UNITED STATES CAN LEARN FROM FRANCE — *B.R. Bergman. New York: Russell Sage Foundation. 184 pages, $34.95 (hardcover), 1996. (800) 666-2211.*

This book contrasts programs offered by France, which has extensive child welfare programs, with U.S. programs, showing how poverty can be attacked successfully. In France, the government runs nursery schools, guarantees medical care and creates strong incentives for parents to seek and hold jobs, with rather good effect, apparently.

TWITCH AND SHOUT: A TOURETTER'S TALE — *Lowell Handler. New York: Dutton (Penguin). 212 pages, $23.95 (hardcover), 1998. (212) 366-2215*

The author is an accomplished photojournalist and has Tourette's Syndrome. Like Dr. Temple Grandin's revelations about herself as an autistic person growing up and adapting to life as a "strangely different" person, Handler's personal account provides keen insight into the life of a gifted individual who happens to have a serious neurological disorder. If it weren't for the odd behavior — involuntary movements, jerks, twitches, angry and obscene outbursts — nobody but Handler and his neurologist-collaborator, Oliver Sacks, would know he had the affliction. The book humanizes and brings the reader close to a disorder that often keeps others at a distance. It is, in fact, filled with humor. Try this, as the reaction of Handler's father when he discovered his son had Tourette's: "Son, neurological disorder is the wave of the future."

THE WAR AGAINST PARENTS — *Sylvia Ann Hewlett and Cornel West. Boston: Houghton Mifflin. 302 pages, $24.00 (hardcover), 1998; (800) 225-3362.*

This is a marvelously informative well documented book, much of it in dialogue form between the authors: a black man who is a Harvard professor who wrote *Race Matters* and is one of the finest lecturers today on the human condition in America, and a white woman who is an economist who wrote the award-winning *When The Bough Breaks*. They team here to discuss "what we can do for America's beleaguered moms and dads." Their theme is that both middle-class and poor parents have been abandoned by our business, political, and cultural elites. They call for a Parental Bill of Rights giving value and dignity to parenting. This, they contend, will restore the nation's commitment to the well-being of kids. Hewlett and West draw on a store of information which they have about American culture, and the contemporary lives of children in the U.S. They are careful observers, and they provide wise and cautious counsel to all who will listen and try to act on their advice.

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Prevention programs
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strengths and limitations of the intervention process. A second panel, charged with assessing the effectiveness of family violence interventions in general, identified 114 evaluation studies that met the panel's criteria for scientific evidence. Of these studies, 78 evaluated child maltreatment prevention and treatment programs.

The studies found that home health visiting prevention programs, such as "Healthy Families," were the most effective intervention efforts. The remaining interventions, including the highly touted intensive family preservation services, were no more effective in preventing and treating child maltreatment than the "standard" interventions.

While there is a great deal of anecdotal evidence about the effectiveness of interventions, and some programs indeed have promise, we have little hard scientific evidence of the effectiveness of treatment and prevention, with the exception of home health visiting.

Why are we failing?

Why have 30 years of innovation and intensive efforts failed to produce prevention and treatment programs whose effectiveness is supported by scientific research?

There are a number of reasons why child maltreatment prevention and treatment programs are not more effective. First, it is possible that the programs, in and of themselves, simply do not work. The theory behind the programs may be faulty and the programs themselves, therefore, may not be addressing the key causal mechanisms of child maltreatment. Second, the programs may be effective, but agencies and workers may not be implementing them properly.

When the evaluation data for the Illinois Family First program were made public, the initial reaction was that considerable variations occurred in the levels of intensity with which family preservation was implemented at the different sites in Illinois, and that the overall implementation was not true to the "Homebuilders" model of intensive family preservation. Thus, the lack of support for effectiveness was blamed on the programs not being properly implemented.

Third, the theory behind the program may be accurate and the program may be appropriate, but the "dose" may be too small. The National Academy of Sciences report, *Violence in Families: Assessing Prevention and Treatment Programs* (National Academy Press, 1998), suggested that the limited effectiveness of family violence interventions may be a function of service providers underestimating the depth of dysfunction in abusive and neglectful families. Because abusive families may be deeply dysfunctional, it may be that more services are necessary or that the length of the intervention should be increased.

Change is not a one-step process

Another problem with child welfare interventions is the crude way behavior change is conceptualized and measured. Behavior change is thought to be a one-step process — one simply changes from one form of behavior to another. For example, if one is an alcohol or substance abuser, then change involves stopping use of alcohol or drugs. If one stops, but then begins again, then the change has not successfully occurred.

A second assumption is that maltreating parents or caretakers all want to change — either to avoid legal and social sanctions or because they have an intrinsic motivation to be caring parents. As a result, those who design and implement child maltreatment interventions assume that all, or at least most, parents, caretakers and families are ready and able to change their maltreating behavior. However, research on behavior change clearly demonstrates that change is not a one-step process. Rather, changing behavior is a dynamic process and individuals progress through a number of stages in trying to modify behavior.

One of the reasons child welfare interventions may have such modest success rates is that most interventions are what researcher James Prochaska, Ph.D., calls "action" programs. These interventions often are provided to individuals and families in what Prochaska and his colleagues call the "precontemplation" or "contemplation" stage of change. This is what others may refer to as denial or ambivalence about the need for change.

Home visits help

The evaluation research suggests that home-health visitors programs are among the better interventions.

David Olds, Ph.D., professor of pediatrics at the University of Colorado Health Sciences Center, and his colleagues evaluated the effectiveness of a home-visiting family support program during pregnancy and for the first two years after birth for low-income, unmarried, teenage first-time mothers.

Nineteen percent of the poor, unmarried teenage girls who received no services during their

pregnancy were reported for subsequent child maltreatment. Of the poor, unmarried teenage mothers who were provided with the full complement of home visits by a nurse during pregnancy and for the first two years, only 4 percent had confirmed cases of child abuse and neglect reported to the state child protection agency.

Follow-up evaluations of nurse home-visiting found that poor first-time mothers who received regular home visits by nurses when the mothers' children were infants had fewer arrests and a lower incidence of drug and alcohol abuse than did mothers who did not receive home visits.

Evaluations are constrained

The traditional response to child maltreatment, while widely implemented, remains unevaluated. Those intervention and prevention efforts that are evaluated tend to be the newer and more innovative attempts to treat and prevent maltreatment.

There are numerous constraints that limit efforts to evaluate any child abuse and neglect intervention, not the least of which is that the gold standard design — a random-assignment experimental design — is often difficult if not impossible to use. Because it would clearly be unethical to assign a maltreatment case randomly to a "non-intervention" condition (even though for the majority of child abuse reports there is in fact no concrete service provided), the control group is assigned the "standard" child welfare intervention. Since we have no empirical data on the effectiveness of these interventions, or even data on how well they are actually implemented, it is difficult to draw conclusions from the few evaluations of child maltreatment interventions. It certainly is possible that the standard child welfare intervention is actually effective, and thus it would take a very strong and powerful innovative intervention to produce a significant difference. On the other hand, it is equally plausible that most child welfare interventions are rather weak doses and that is the reason so few studies have been able to demonstrate a significant effect. ■

Richard J. Gelles, Ph.D., is the Joanne T. and Raymond B. Welsh chair of child welfare and family violence, School of Social Work, University of Pennsylvania. His latest books are *The Book of David: How Preserving Families Can Cost Children's Lives* (Basic Books) and *Intimate Violence in Families* (3/E), (Sage Publications).

Being objective
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placed in a foster home. The foster home, while adequate, was less than ideal, and it was painful for him to stay there for months on end while he waited for the wheels to turn so he could return home. Needless to say, he was in chronic distress and his future was uncertain. At the end of one session, he simply refused to leave my office so he would not have to return to the foster home.

After much therapy, regular contact with DFCS workers and involvement with his father, the boy was placed in his father's custody, where he clearly belonged.

Waiting for DFCS to move on the situation was frustrating. It was hard not to become angry because they were taking so long to return the boy to his rightful place. But I knew I had to accept the agency's schedule, however slow, and remain calm in order to provide emotional support to my client. If I had not maintained appropriate objectivity and boundaries with father and son, they would have seen my distress and that would have made the situation even more difficult for them.

Rising to the task

Another recent encounter with an abused child raised other issues for me as a therapist. The client was an 11-year-old girl who had a pleasant disposition, despite having been sexually abused. She had never known the identity of her natural father, and when she came to me, her mother had been incarcerated for several months as a result of various offenses.

The child was fortunate in that she had been allowed to live with relatives, but as so frequently happens with sexually abused children, she had problems with attachment and a poor sense of personal identity. During our initial therapy session, she was accompanied by her caseworker, who assured the child that I was someone she could trust and who could provide help for the aftermath of her sexual abuse, neglect and deprivation.

The caseworker's absolute reassurance to the child left me feeling daunted by the task of trying to live up to their high hopes, while making a conscious effort to avoid becoming too involved by taking on a parental role.

Heavy scrutiny adds pressure

In an age where mental health professionals are heavily scrutinized, appropriate caution and

planning are absolutely necessary if we are to remain ethical, maintain our professional reputations and avoid unnecessary legal involvement.

Abused and neglected children have many issues. Often, they have not bonded appropriately with an adult. They have feelings of insecurity, inadequacy, worthlessness, hopelessness and helplessness. Mood disorders (especially depression) are common among these children and they are overwhelmed with emotional needs that are rarely, if ever, fulfilled. It is not surprising, then, that they often overreact to the empathy, personal attention and bonding that occurs during therapy.

These children may suffer from posttraumatic stress. Therapists often are forced to deal with severe anxiety, fear, mistrust, painful memories, emotional distress, avoidance, anger and hypervigilance. In these cases, it is easy to become overinvolved with a child, and hard to maintain interpersonal boundaries. The potential for the child to overreact to a therapist who has become less objective and too involved can be great.

Be prepared

I have found that, for me, the most effective way to deal with these problems is to be well prepared by carefully reviewing the client's social history and consulting with referral sources, foster parents and natural parents. Being aware of the child's personal issues and traumatic experiences helps me to complete a tentative treatment plan. With a useful plan completed ahead of time, it is easier to provide structure during treatment.

Therapy is an art, not a science. Several experts have shared various therapeutic approaches for abused children that work well. I have found the techniques developed by Karp and Butler (1996) and Pearce and Pezzot-Pearce (1997) especially helpful. Karp and Butler offer a session-by-session approach to issues such as personal identity, goal setting, trust, emotional expression, boundaries, safety, painful memories, guilt and shame. I have found that using their techniques helps me keep the therapist-patient relationship professional and ethical. Pearce and Pezzot-Pearce's approach provides useful information in regard to the therapeutic relationship, development of coping skills and termination of therapy, which can be difficult.

Coping strategies

As therapists, we must remember our vulnerability to sensitive issues not only on behalf of our patients, but as they relate to us. I have found consulting with other therapists in my office before and/or after difficult sessions to be indispensable. Also, I try to schedule times between sessions to "catch my breath" and relax as much as possible. When it's not possible to implement these coping strategies, I try to schedule the more stressful cases either right before lunch or as my last session of the day. I have learned that I become overwhelmed if I schedule too many of these children in one day. When this happens, I adjust my schedule as necessary.

And last but not least, I believe it is vital that we know ourselves and admit our own vulnerabilities in order to be truly effective therapists. ■

Ronald L. Simmons is a licensed psychologist with Northwest Psychology Associates in Canton, GA.

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These two books come as a kit, and sell for $29.50 (softcover) and $57.95 (hardcover).

PSYCHOTHERAPY OF ABUSED AND NEGLECTED CHIDLREN — *John W. Pearce, Terry D. Pezzot-Pearce. New York: The Guilford Press, $ 38.95 , hardcover, 1997. (800) 365-7006.*

CLINICAL HANDBOOK OF CHILD ABUSE AND NEGLECT — *Lane J. Veltkamp, Thomas W. Miller. Madison, Conn: International Universities Press Inc. (ask for stock #00950), hardcover, $27.50, 1994. (800) 835-3487.*

KEEPING UP THE GOOD WORK: A PRACTITIONER'S GUIDE TO MENTAL HEALTH ETHICS — *Leonard J. Haas, John L. Malouf. Sarasota, Fla. Professional Resource Exchange Inc., $32.95, hardcover, 1995. (800) 443-3364.*

Guest Commentary

Ignore child abuse now, attend to adult social problems later

By Betty W. Phillips, Ph.D.

Research has shown that child abuse is one of the many critical links to problems of youth and later adulthood. A preponderance of individuals with serious problems — in some studies up to 90 percent — have been victims of child abuse, according to published studies. The later problems include alcohol and drug abuse; criminal and gang activities; emotional disturbances and mental illness; prostitution; runaway behavior; teen pregnancy; sexual offenses; suicide; and violent crime. Other social problems such as physical ailments; sexual dysfunction and identity problems; school failures and dropouts; and unemployment and underemployment show the disproportionate influences of child abuse.

Some investigators insist that child abuse may be the most damaging influence on the development of children, and consequently on the increasing incidence of serious social problems.

Among the most serious and enduring consequences is the influence on the development of the survivor's identity, either as victim or victimizer.

Beyond the immediate and visible physical trauma of the abuse, the hidden emotional and social consequences are even more devastating. Abused children have been documented repeatedly as having serious deficits in all aspects of their emotional and social development, including self-esteem and interpersonal skills. These deficits begin with damage to the victims' basic trust — often violated by their own parents.

Among the most serious and enduring consequences is the influence on the development of the survivor's identity, either as victim or victimizer. Abuse also inflicts demonstrable damage on other aspects of the child's development, including language, intellectual skills, academic potential and health status.

But there are other issues that the public generally doesn't know about child abuse, including these:

- The abused child usually knows his/her abusers well; indeed, they are often family members.
- The child is forced into protecting the secret abuse instead of seeking help.
- Treatment of victims is sorely lacking.
- Child protection systems fail to cope with the rapidly escalating problem.

Exacerbating the problem is the secrecy surrounding child abuse, formed in part by the deep ambivalence of adults about recognizing and understanding the pain of traumatized children. But it is a problem we cannot afford to ignore. The skyrocketing economic costs of child abuse are now being documented in many systems, including medical treatment, hospitals, law enforcement, prosecution, prisons, psychiatric institutions, special education, foster care and residential placements, as well as in the high costs of health and other insurance.

In some studies, early treatment of child abuse victims has been shown to be a cost-effective alternative, not only in immediately helping the victims, but also in preventing revictimization and intergenerational transmission of abuse. Current data on this point are suggestive but not definitive. Unfortunately, because of underfunding, many social and mental health programs fail to be very effective. This lack of effectiveness reinforces public skepticism about paying for prevention and treatment.

Because decision-makers confront a seemingly endless list of problems that compete for attention and funding, child abuse has been approached as just one more item on the list. We must make child maltreatment a priority, and educate the public about what the failure to develop a comprehensive child protection and treatment system will cost in the long run. ■

Betty Wismer Phillips is the author of the report "The Austin Challenge: The Crisis of Child Abuse in Our Town."

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ISSN 0898-2562

The Brown University Child and Adolescent Behavior Letter

Providing the link between behavioral research and your clinical work.

Special expanded back-to-school report

School testing can be a form of child abuse

By Theodore R. Sizer, Ph.D.

Testing is the name of the school reform game, at least in the states and large urban school districts.

Tests are a vehicle for what appears to be a straightforward and well-intentioned policy. The schools, the argument goes, are not delivering for many children. So we must raise academic standards. Setting clear academic goals and then testing for whether each school has met them for each child will create the necessary pressures for improved performance. Schools whose students meet the standard will be rewarded. Schools that do not deliver will be helped. If the help does not yield desired results, these schools will be shut down, or, as current jargon has it, "be reconstituted."

The human mind, imagination and grit are too complicated to be so simplistically classified.

The strategy's persuasive rationality masks several problems, three of which are especially serious.

First, the critique rests on the assumption that the reason for student failure in American schools arises from the lack of clear goals and of children's and teachers' efforts. By omission it implies that the ways schools conduct their business — their design and culture — are basically satisfactory. What is needed, it is assumed, is merely some guiding direction and the pepper of threat. The evidence, however, is that most schools, especially high schools, are seriously ill-designed to sup-

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Insert

This month's client handout:
How to choose after-school day care for your child.

Campus Drinking

Social pressure, not peer pressure, leads students to drink

By Jordana Haspel

Last year, episodes of binge drinking on college campuses resulted in several student deaths due to alcohol-related causes. But many students, including non-drinkers, don't see drinking as a big problem. Koreen Johannessen, M.S.W., director of health promotion and prevention services at the University of Arizona, says, "I think professionals would like to think students see [campus drinking] as a problem, but for most people it isn't much of a problem. I don't think students are concerned."

Conversations with students confirmed her assessment. "I don't think there's anything wrong with it, if they know their limits," says Zach, a student at the University of Virginia. "[But] if that's their sole reason for coming to school, I think that's kind of lame."

Students do express concern about safety. While general warnings about the dangers of drinking do not seem to faze them, they often have picked up on one or two safety points from intervention efforts. This is consistent with research, which has

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Theodore R. Sizer, Ph.D., University Professor Emeritus, Brown University; Chairman, Coalition of Essential Schools; former director, Annenberg Institute for School Reform

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The Brown University Child and Adolescent Behavior Letter (ISSN 0898-2562) is published monthly by Manisses Communications Group, Inc., 208 Governor St., Providence, RI 02906; (401) 831-6020; fax: (401) 861-6370; e-mail: lwjackim@manisses.com. Yearly subscription rates are $167 for institutions and $117 for individuals. Periodicals postage at Providence, RI. POSTMASTER: Send address changes to: Manisses Communications Group, Inc., P.O. Box 9758, Providence, RI 02940-9758. ©1998 by Manisses Communications Group, Inc. Member, Newsletter Publishers Association. **The Brown University Child and Adolescent Behavior Letter** reports monthly on work in child development. Our purpose is to provide timely, accurate information by drawing on professional journals, expert opinion and the experience of our editors and guest writers. **The Brown University Child and Adolescent Behavior Letter** does not offer medical, legal or administrative services and we encourage subscribers to seek advice from qualified professionals. **The Brown University Child and Adolescent Behavior Letter** is available in reference systems produced by Information Access Company. For more information, contact Information Access Company, Rights & Permissions Dept., 362 Lakeside Drive, Foster City, CA 94404, or call (800) 227-8431 (U.S. only) or (415) 378-5000. All rights reserved. Reproduction forbidden without the consent of the publisher. Authorization to photocopy articles for internal or personal use or the internal or personal use of specific clients, is granted by Manisses Communications Group provided that the fee of $6.00 per article is paid to the Copyright Clearance Center, 222 Rosewood Drive, Danvers, MA 01923; (508) 750-8400.

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Learning Disabilities

ADHD symptoms may mask a language-based disability

By Jonathan Green, M.Ed.

Much has been written about the overdiagnosis of children with attention-deficit/hyperactivity disorder (ADHD) and their subsequent overmedication. In part, this may be due to other, more subtle language-based disabilities that go undiagnosed and untreated because they affect attention and suggest ADHD symptoms.

For example, children who process language slowly can become quickly saturated and overwhelmed with language, especially in a classroom when the teacher-student dialogue is moving at a quick pace. Others may have receptive language difficulties that may limit auditory memory, or cause difficulty with word meanings. Some students exhibit inattentive behaviors when this happens.

To date, the best method for diagnosing ADHD is observing the child in situations where specific attention is required; interviewing the child, parents and teachers; and conducting a comprehensive evaluation that includes a psycho-educational and speech and language evaluation.

Language-based learning disabilities occur in endless permutations and combinations and, even when they are mild, can be very debilitating. Many children who have mild language disabilities can naturally compensate, but when those children also have attention deficit they can be severely handicapped. Dyslexia and ADD can be a lethal combination because frequently these children are quite intelligent and they can mask their reading difficulties with ADD-type behaviors. It can appear that the reason they are having difficulty decoding or comprehending written language is their inattention, rather than a language-based learning disability. Perhaps this is why these children are so often mislabeled as lazy, unmotivated or solely ADD.

Stimulant medication can have profoundly positive effects on ADHD children by allowing them to "quiet the tornadoes" in their heads and providing "reading glasses for the brain," but too often these children are on the wrong type of medication, the wrong dose or an inconsistent schedule. While medication can be extremely effective by reducing symptoms, it almost always needs to be "tinkered with" in terms of the dose, the best medication(s) or the right combination of medications. This requires patience and good communication between adults and with the child.

Just as important, any pharmacological intervention needs to be part of a comprehensive diagnosis and treatment plan. Frequently, medication is not effective when it is the only strategy being employed for a child with ADHD *and* a language-based learning disability. By itself, medication does not make a child better organized or improve the syntax of written expression. Rather, it "levels the playing field" and reduces the interference

so that a child can learn skills necessary for success in school.

Frequently, because of their ADHD (and low frustration levels), these children have not had the benefit of practice over time. So they not only have not improved certain skills, but, more important, they have not developed good habits to further their skills. For young children, this may mean that they have not experienced that nurturing story time before bed when a child nestles into a mother's or father's lap. For older children, they may not have playmates because their classmates do not understand their behavior. And, during those crucial intermediate elementary years and beginning middle school years when students are "reading to learn" and learning to socialize, children with ADHD become more alienated from their friends and teachers.

This is why comprehensive early intervention is so vital. Children who systematically fail in school will always develop secondary problems that usually are not constructive and complicate the treatment plan. Thus, the longer the child's ADHD and learning disabilities are not properly diagnosed and effectively managed, the more at risk a child becomes.

Specific strategies vary from child to child. A comprehensive plan for an ADHD child at The Hamilton School at Wheeler has included the following:

- Medication.
- Consistent classroom expectations and consequences.
- Regular and effective family therapy.
- Direct social-skill instruction.
- Physical activities, including organized sports that release energy and promote team building, or individual activities — such as karate — that promote concentration.
- Individual tutoring.
- Organizational structures.
- Behavior modification techniques in school and/or at home.
- Regular communication mechanisms between home and school.
- Helping the child to understand his/her disabilities so that the child can strategize and advocate on his/her own behalf.
- Multi-modal teaching (auditory, visual, kinesthetic).
- Coaching and cuing.
- Teaching memory devices.

The list of strategies is unlimited, of course. What is important is that the child's disabilities are correctly diagnosed and that the strategies that are implemented are comprehensive in nature, involving all the major aspects of a child's life. Evaluating any treatment plan must always be an ongoing process. ■

Jonathan Green is program director at The Hamilton School at Wheeler, Providence, R.I., a school-within-a-school for children in grades one through eight with language-based learning disabilities.

Keep Your Eye On

... methylphenidate distribution.

According to Wisconsin researchers, 16 percent of 161 students in rural and small-town schools who were prescribed methylphenidate (Ritalin) for attention-deficit/hyperactivity disorder (ADHD) had been asked to sell, give away or trade their medication to others. The researchers emphasize the importance of improving storing and distribution procedures for methylphenidate and other medications at schools. The Milwaukee Journal Sentinel reports that school policies often are lax regarding medications stored for students. Some schools allow students to simply carry their medications in their pockets instead of locking them in a centralized storage area. (*Alcoholism and Drug Abuse Weekly*, July 27, 1998)

... fetal REM sleep.

New research on activity patterns associated with rapid eye movement (REM) may help explain why fetuses have a greater need for REM sleep during development than at any other time of life. At McLean Hospital in Belmont, Mass., and other centers around the United States, Carl M. Anderson, M.D., a research fellow in the developmental biopsychiatry research program, studied fetal sheep and found they spent as much as three-fourths of their time in a state similar to adult REM sleep.

According to Anderson, fetal REM sleep has long been thought to help organize and stimulate the fetal brain during development. In 13-day computerized recordings of sleep in the sheep fetuses, the study found there were "bursts" of REM sleep that occurred in organized patterns. Such bursts were repeated at different times, which he says "increases the probability

of coordination between the maturing body and brain."

In addition, in the past, researchers thought that nightly dreams were "chaotic" and that they occurred from "random neuronal firing," Anderson adds. But he says those theories "may not be well-founded." In fact, the fetal sheep study findings indicate that the regular bursts of REM sleep may actually be organized patterns that occur naturally in the frontal lobe regions of the brain.

For more information, contact Carl M. Anderson, M.D., Developmental Biopsychiatry Research Program, McLean Hospital, 115 Mill Street, Belmont, MA, 02178-9106. Telephone: (617) 855-2000.

... lead screening.

The American Academy of Pediatrics (AAP) in Elk Grove Village, Ill., recommends that pediatricians step up their efforts to screen children for lead poisoning. Although the number of U.S. children ages one to five with elevated blood lead levels decreased from 88.2 percent between 1976 and 1980 to 4.4 percent between 1991 and 1994, almost 900,000 children still had elevated levels of lead in their blood between 1991 and 1994.

The AAP now recommends targeted blood screening for lead in only high-risk areas and population groups. Previously, the organization had recommended screening all children at ages one and two.

The AAP recommends that pediatricians develop risk-assessment questionnaires for parents in conjunction with their local health agencies. It also recommends universal screening in areas where at least 27 percent of housing was built before 1950 and in areas where the percentage of one and two-year-olds with elevated blood lead levels is at least 12 percent.

For more information, contact Heather Cunningham, American Academy of Pediatrics, 141 Northwest Point Boulevard, Elk Grove Village, IL 60007-1098. Telephone: (847) 981-7131.

Recommended Reading

MEDICATIONS FOR SCHOOL-AGE CHILDREN: EFFECTS ON LEARNING AND BEHAVIOR — *R.T. Brown and M.G. Sawyer. New York: Guilford Publications Inc. 228 pages, $27.95 (hardcover), 1998. (800) 365-7006.*

SCHOOL EXPERIENCES OF GAY AND LESBIAN YOUTH: THE INVISIBLE MINORITY — *M.B. Harris, Ed. Binghamton, N.Y.: Haworth Press. 115 pages, $14.95 (softcover), 1997. (800) 944-8648.*

THE ATTENTION ZONE: A PARENTS' GUIDE TO ATTENTION DEFICIT/HYPERACTIVITY DISORDER — *M.W. Cohen. Bristol, Penn.: Brunner/Mazel. 234 pages, $21.95 (softcover), 1998. (800) 825-3089.*

What's New in Research

Cocaine overdose riskier on hot days

Recent research suggests that high temperature is associated with a significant increase in mortality from cocaine overdose.

In a study of all unintentional cocaine overdoses from 1980 through 1992 (1,382 people) and all deaths due to hyperthermia among cocaine users (10 people), results were evaluated to identify a maximum daily temperature threshold above which death from cocaine overdose was more likely to occur. The researchers also evaluated all cases of fatal unintentional cocaine overdoses from 1993 to 1995 (2,008 patients), as well as four comparison groups that included patients who had died of unintentional opiate overdoses (793 patients), all other fatal unintentional overdoses (85 patients) and two subsets of homicides (4,638 patients) and motor vehicle fatalities (815 patients) who had positive cocaine toxicology test result on days when temperatures were above average.

A threshold temperature of 88 degrees was identified, and the mean daily number of fatal cocaine overdoses increased steadily above that temperature. The mean daily number of cocaine overdose deaths was 2.34 on days when the temperature was above 88 degrees, compared to 1.76 on days when the temperature was below 88 degrees.

Marzuk PM, Tardiff K, Leon AC, et al.: Ambient temperature and mortality from unintentional cocaine overdose. *Journal of the American Medical Association* 1998; 279:1795-1800. For reprints, contact Peter M. Marzuk, M.D., Department of Psychiatry, Box 140, The New York Hospital-Cornell Medical Center, 525 E. 68th St., New York, NY 10021.

How to find the right before- and after-school program for your child

Finding quality care for school-age children can be a problem. The following tips can make the search easier:

- Explore all types of care options — family child care, centers or programs offered through other institutions such as the YM/YWCA, scouts, churches, school districts or others. Visit several programs. Do they look safe? Do staff members enjoy talking and participating in activities with the children? Are the activities and ages of the children a good fit for your child? After your child starts attending a program, be sure to go back and check it out regularly.
- Ask your child what types of programs he or she would like. Involve children in the decision-making. Look for programs that focus on their interests. Ask about the training and experience of all adults who will be with the children. Do they have first aid and CPR training? Are their discipline policies compatible with your philosophy? Are the children able to choose among activities? What do the adults know about child development? How will they encourage your child's independence and build self-esteem?
- Count the number of adults and the number of children they will be supervising. Be certain there are enough adults to supervise all planned activities.
- How long has the program operated? What percentage of children return each fall? Is the program certified or accredited by a professional association? Check references from parents whose children have attended in the past.
- Find out about efforts in your community to expand and support after-school child care options. For more information, contact your local child care resource and referral agency.

For older children:

- ✔ Consider enrolling your child in the same after-school child care program as his or her best friend.
- ✔ Children over age 12 may benefit by being in leadership-training programs.
- ✔ Remember to ask about additional fees for such things as field trips and transportation.
- ✔ Find out if the program offers or arranges transportation to and from school.
- ✔ Make sure your child's nutritional needs will be met either by the program (sometimes children enjoy making their own snacks as an activity) or by your own "brown bags."
- ✔ Determine whether the program sets aside time for your child to complete homework assignments and be with peers.
- ✔ Assess whether the program has enough equipment to keep all the children occupied.
- ✔ Find out whether the children have access to community resources such as ice-skating rinks, swimming pools, libraries, museums and youth centers through the program.
- ✔ Investigate the provider's insurance coverage to get a clear understanding of what they expect your family's insurance to cover if anything should happen to your child.
- ✔ Be sure to ask about scholarships or financial assistance that may be available.

For more information, contact Child Care Aware, a Washington, D.C.-based nonprofit initiative whose mission is to ensure that parents have access to good information about quality child care and local resources. Child Care Aware can be reached through its national toll-free hotline at (800) 424-2246, or it's Web site at www.childcarerr.org/childcareaware. Child Care Aware connects parents to the child care resource and referral programs in their community where they can receive local child care information and services. Parents also may call the national hotline or e-mail Child Care Aware to receive a free brochure and checklist to help them make their best child care choices.

Continued, over ...

Parents can help children adjust to a new school

Each year many children must transfer to a new school. Child psychologist Dr. Lawrence Kutner urges parents not to underestimate the importance of this move in young people's lives. Children ages five to seven may feel upset at changes in the predictability of their daily routines. Older children and adolescents are likely to grieve over the loss of specific peer groups. Parents can do a great deal to help their children manage the transition. Kutner offers the following tips:

- ✔ Recognize that a move across town may be just as stressful for children as a move to a different state.
- ✔ If you move during the summer, encourage your children to enroll in a summer sports program or enrichment class at their new school. These activities will give them a chance to meet some of their classmates in advance.
- ✔ Try to avoid mid-year transfers. Children who join a class after social alliances have been forged are more likely to remain outsiders for the remainder of the year. The period between elementary school and junior high school or junior high and high school is an ideal time for a move.
- ✔ Make sure your children's school records are sent ahead to the new school, perhaps along with written notes from their former teachers. This information will prevent teachers from adding to children's frustration by assigning work that is too hard or too easy.
- ✔ Don't be surprised if your children take up to a full year to adjust.

The Brown University Child and Adolescent Behavior Letter

Editor's Note: Subscribers are permitted to photocopy multiple copies for clients and colleagues who would benefit from the material. Not for resale or mass distribution. Part of this article originally appeared in *The Brown University Family Therapy Letter* in 1990. We are reprinting it as a service to our readers.

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PLACE YOUR BUSINESS CARD HERE BEFORE PHOTOCOPYING

'Enhancing' the truth in order to compete destroys students' optimism, promotes cynicism

By Nancy Faust Sizer

As a high school history teacher with 25 years of experience, I thought I could look at students in their senior year with a certain amount of perspective. I knew that a transition year was likely to be distracting in ways that would be hard in the short term for both teachers and students. Still, I couldn't explain the cynicism that also seemed to be the students' trademark.

In 1994, I left the classroom and did interviews with seniors all over the country in order to learn directly from them their feelings about the senior year, the year in their lives that we consider childhood's end. They were eager to talk and they spoke with sensitivity and candor.

The "senioritis" syndrome

This is *the* year at the high school, no doubt about it, and all eyes are upon them. This is also the year, however, in which they must put a tremendous amount of time and thought into getting somewhere else. "Senioritis" — the conviction that they won't be all they can be — sets in.

In the fall, seniors not onlyneed to earn the highest possible grades in tough courses, they need to star in the school play and at the same time write a college essay about starring in the school play. They are expected to be fully engaged in the present, but also fully engaged in planning for the future. Thus, they are expected to live, and be at their best, in two time dimensions at once.

But the culture of senior year is not just about inevitable and difficult transition. My interviews also gave me new insights into how dishonesty, cynicism and rudeness may have become part of it.

Americans take pride in the fact that we let our children be children. Most of us don't line our babies up to compete for a place in ever-more-selective institutions. Instead, we encourage them to enjoy long summers, sports, friendships, jobs and other interests outside school. Teachers seem to accept these priorities, and they make learning more acceptable by presenting schoolwork that will genuinely engage their students. Some brave teachers place emphasis on a real understanding of how information can be integrated into one's actions, one's thoughts, one's life over the more sterile and transitory "coverage" of a mass of academic material that life in the real world doesn't require. After all, one can always use a map to find the way to Kansas. Yet the relentless memory work that is everybody's least favorite aspect of school is suddenly important even to the students, who have become concerned about their test scores. They know that this "coverage" is required so that they can measure up against the competition. As they see it, and they're not wrong, they will soon need to reduce their whole lives to a couple of sheets of paper filled with highly significant numbers and letters.

Playing the game

The gatekeepers for the next phase of the seniors' lives say they simply don't have the time or money to give the seniors a chance to show what they do know and can do. Instead, the seniors, especially those applying to college, are asked to provide the data by which they may be eliminated from the prize they want. Colleges may not see it that way, but most of the students do, and in that moment of vulnerability, they begin to do what one of my interviewees called "playing the game."

It's not a straightforward game that they are playing, with a level playing field and the understanding that, win or lose, they'll have a good time. It's time to line up for the passage into the real world.

The vocabulary of gambling enters their language. The odds feel like long ones because so many seniors have been told to dream, to reach for something that is just outside their grasp. This is meant to encourage them to try hard and keep growing, and for some it works. But for too many seniors, playing the game becomes a dishonest process. It should not be surprising to us that the students who are measuring themselves against such high standards, most of them for the first time, feel that they will fall short. And if they are

given the message that they cannot face honest measurement, they must figure out a way to add a few "lifts" to their shoe.

Let's face it. The message our seniors receive from adults is all about how to deceive. Here are only a few examples of what they absorb every day, in every town and every high school.

- ✓ Take courses that sound hard but really aren't.
- ✓ Write a first paper that dazzles the teacher so that your grades will stay high all term.
- ✓ Get your teacher and/or parent to help you rewrite your college essay; it's not that different from wearing your mother's suit to your interview.
- ✓ Take test-prep courses; it isn't that different from going to hockey camp.
- ✓ Make sure you do a little community service, and it won't hurt to write your essay about it.
- ✓ Pad your resume, especially with "leadership positions" even if it's a tiny club that you just started.
- ✓ Get friends of your uncle who have "pull" to write you recommendations, even if they don't know you that well.

Watching the adults around them lose their own bearings, facing a real world that requires so much posturing, so much manipulation, has made many of the seniors lose heart.

Values in conflict

Other messages aren't as blatantly dishonest, but they reflect values that are certainly at odds with those expressed by the seniors in their essays and interviews:

- ✓ As soon as your grades don't count — that is as soon as outsiders are no longer looking over your teachers' shoulders — you can quit working in school
- ✓ As soon as you have had a favorable write-up in the local paper, you can quit the team.
- ✓ As soon as your toughest teacher has written your recommendation, you can drop his course and take an easier one.

None of these recommendations is particularly venal, but they are replacing advice we gave our seniors earlier, back when they where children developing honest interests and talents and moving toward a well-led life. Furthermore, the seniors gauge their maturity, as do many of the adults around them, by how well they receive this new advice. They are urged to present themselves to the "real world" as impressive products rather than as works in process. They are told to play the game.

Adults are also drawn into this game-playing. Rare is the parent who can resist supplying help, or one of those shoe lifts that makes his child appear taller than she is. It's easy to cross the fine line between giving moral support, visiting colleges and keeping track of applications, to "enhancing" your child's essay, while you type it for her "with just a little editing help." This dilemma is complicated by the looming deadline and the agitation that everyone is feeling under the pressure.

Temptation may rear its head again when parents are filling out financial aid forms. (How much equity do we really have in the house?) It's a hard time to be honest, although a surprising number of parents manage it. In addition, if parents decide to let their senior present himself in his everyday shoes, without the lifts that others may have assumed for the occasion, they are so afraid that they may have hurt their child's chances that they don't talk about it. Thus their message of honesty never gets sent and never cuts the pervasive messages of dishonesty that are clogging the airwaves. And, worst of all, without those lifts, their senior actually will be at a disadvantage when measured up against those who have "enhanced" their applications.

Some teachers are caught up in the deception too. They promote deceit by describing their pet projects as "good for your resumé." They are expected to grade more leniently during the fall term of the senior year. They inevitably tell only part of the story when they write recommendation forms. Their hands are mysteriously drawn rightward toward the "outstanding" column, and they never use the one on the far left. They find themselves pretending that their school is that one near Lake Wobegon, where all of the children are above average.

Watching the adults around them lose their own bearings, facing a real world that requires so much posturing, so much manipulation, has made many of the seniors lose heart. Even when they find a place to go to after high school, they feel a little suspicious about how they got there. If the seniors have not been allowed to present their own real work, if instead they have presented a bunch of numbers and letters, or their family's wealth or their race or their throwing arm or their uncl s contacts or an essay that doesn't sound like them anymore, they can be less confident about the real accomplishments that they have made in high school.

The culture of deception dispirits them. Cynicism replaces optimism, and they face the big changes in their lives with more of a sense of what they are getting away from than what they're going to. In school after school, students told me that senior classes don't matter anymore, but there's always the prom.

'You'll be fine,' as an adult answer to the students' worries, is universally inadequate.

Still, I'm not wallowing in despair; I have ideas about what we can do about it.

Solutions

If the widespread phenomenon of senioritis were based on an individual's own laziness and sense of entitlement — which is what most people think — there would be little that we could do about it, but if it's based at least in part on a culture of deception that has come to surround the seniors, we need not despair; there are remedies. They are not easy ones, but they exist. The most powerful way that teachers and parents can help their youngsters to avoid senioritis is also the most difficult. They can keep their own bearings in the face of competition, so that the model the seniors are watching is a steady and purposeful one. The fact that some colleges are selective and will not be able to select all the good students who apply cannot be denied; to do so would be to mislead the seniors. "You'll be fine" as an adult answer to the students' worries, is universally inadequate. Coping strategies must be devised and discussed thoroughly, but they need to be scrupulously honest so that the seniors will sense the adults' basic confidence in the way the world works as well as in their seniors' ability to function in it.

It's undoubtedly part of parenthood to want the best for one's kids, even at the expense of other people's kids. Yet it's even more parental to look to the long term instead of the quick fix. This is why parents urge their kids to brush their teeth, to eat their vegetables. This is why teachers spend a lot of time helping their students avoid spelling errors. Adults know that activities can become good habits tomorrow and that habits are what will matter over a person's life. The college admission that was gained by shaving the truth is not likely to lead to a long-term advantage because the habits being displayed are not honorable or effective ones. This is what the seniors cannot know from personal experience; adults can, so it's up to them to shape an environment in which seniors can be helped to trust themselves.

Shape attitudes early

But can we reshape attitudes about competition? Specific activities will help. From an early age, at home and at school, a child can be encouraged to present a picture of himself that is evolving, improving and at the same time honest. In school, students should be exhibiting their work from an early age. Many are already doing so, starting with the drawings that a three-year-old may bring home from nursery school. As the student grows, however, attention needs to be paid, not just to the math problems, but to the reasoning that went into them. Not just to the painting, but to the areas that still need work. Not just to the information about Shakespeare, but to the line in *Hamlet* that seems most evocative to the student, and to the variety of explanations that might be given for it.

It's not enough just to present increasingly complex work. In every presentation, time needs to be made for questions and real feedback. This time is most often given one-to-one, at the bottoms of papers, but it can also take place in a group, and it's most effective when the group includes some of the people who will eventually make up a college admissions decision. The trust involved in making this interchange both candid and respectful can take years to develop. It's effective, but it's not usually efficient: it requires a great deal of time, care and emotional resilience

to give honest assessment of another's work, and even more to take feedback to heart.

Over the years, however, with every important piece of a work, a student can gain greater ability to present himself honestly and well. She realizes how many drafts it may take her to produce writing that is both authentic and clear. He listens to himself on the tape recorder and hears how many "you knows" he inserts into his speeches. She admires the posters or the papers or the presentations of others, while there is still time to put in a little more effort on her own. For students who have had this kind of practice throughout high school, the big job of impressing strangers will not seem so impossible without "enhancement."

Senior seminars

During senior year, there is much to do, and it too will require a considerable amount of time from both teachers and students. Instead of insisting that the seniors research colleges by reading a large number of books on the subject on their own time, a seminar should be made part of the senior's program. It would be devoted to helping seniors to do this big job honestly without having to look for short cuts. The assignments would change over the year as the demands of the senior year change. During the fall, groups of seniors might check out future options in the workplace or college: graphic design or engineering, music or classical languages. The watchful eye of the teacher can help them guard against hearsay and strictly anecdotal evidence to make their work thorough and reliable. This is research that matters, and if a paper on Napoleon has to be sacrificed in order to give the seniors time, so be it. The seminar's focus may well be different for each student depending on how much help he has outside of school and what her financial options are. But if the class is kept small, the teacher will be able to help each student to design a challenging project of use to himself and others.

Over the years, I have sensed a growing frustration in my students as they realized that finding and gaining admission to a good college is hard work for which they have not really prepared. They have sent away for catalogs, but not known how to read them. They have applied to a local college because they haven't learned enough about other options. They have been dissuaded from perfectly reasonable places because somebody's cousin didn't like it there back in 1983. They have had others rewrite their college essays because they feared that they would not do well without a lot of help. If we teachers can find it in our hearts to honor their challenge by giving them the time to do it well, we will help them avoid the panic that can lead them to act foolishly, short-sightedly and dishonestly.

Deal with emotions

Giving the students time to do their job well is not all that we must do. We must help them to deal with the stress that comes from measuring up to their own and others' expectations. We must know our students well enough so that we can help each one of them to deal with the emotions that inevitably accompany leaving a familiar place, presenting themselves as they really are, finding a new venue that will bring out the best of their talents and coping with disappointment.

Finally, and after all that coaching and patience, we must accept that the choices they make will be their own. There will be rocky moments during the year, but by graduation the seniors will have negotiated a complex passage, and will be the optimistic and impressive young adults that we want them to be. ■

Nancy Faust Sizer is acting co-principal of the Francis W. Parker Charter School in Devens, MA. She has just co-authored a book, *The Students are Watching: Teaching Toward a Worthy Life* (working title), to be released next summer by Beacon Press.

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School testing
from page 1

port serious learning, a problem not correctable with mere tinkering.

Second, just who will set those "high-stakes" high-level academic goals? School curricula, especially beyond the rudiments, are an arena for bitter culture wars, battles that speak more to grown-ups' politics than to children's development. Serious education is about affecting children's minds. Who — beyond families — should have the right profoundly to affect those minds? A "high-stakes" state school system with a single particular curricular ideology raises fundamental problems of intellectual freedom for citizens and academic freedom for teachers. In the recent rush to set higher academic standards, this issue has been largely ignored, but as these "standards" are beginning to emerge in politically volatile states such as California, it is coming to the fore.

What do tests predict?

The third question has to do with testing, and the accuracy with which mass-administered instruments in fact catch the substance of learning. The existing evidence is profoundly troubling, especially for subjects, skills and student attitudes beyond the rudiments of literacy and computational mathematics.

Of course, there are many tests for many purposes. Some are better than others. Few, including even the fabled Scholastic Assessment Tests (SAT) of the College Board, are good predictors of an individual's long-term intellectual performance, save at the extremes. Most focus on one or at the most two of what Howard Gardner has identified as "intelligences." Students with strengths in these are labeled as "bright," but highly promising students with important and marketable talents in other areas receive no such accolade.

These and other troubling realities are well-understood by the testing community but often ignored by policy leaders. The latter ask Americans to equate educational excellence with a score on but one or two tests. This is egregiously unfair both to serious test makers and to many, if not most, test takers. The human mind, imagination and grit are too complicated to be so simplistically classified.

Methods are limited, abusive

However, many states today appear ever readier to classify young people in just such simplistic ways. Given the scholarly evidence about limitations of most mass-applied assessment systems, such classifications — especially if they are "high-stakes," meaning that children are sorted and classified on the basis of them — constitute a serious form of child abuse.

There is nothing at all wrong with testing, or with the state as well as parents wanting to know just how each child is learning. Good teachers "test" daily. Rather, it's the simplistic mechanization of this practice that is pernicious.

Let none of us make too much — or too little — about "test scores." Before drawing judgments from them, let us be sure we know a great deal about the precise test that was given, its scholarly record for immediate relevance and its history as a sound predictor of future performance. Let us be sure that no one assessment, or no single assessing authority, has complete claim to any sort of calculation or action about a student arising from that calculation.

And let us remember that humans develop in often unpredictable and extraordinary ways and that depending too much on any sort of "science" to judge a human's worth is exceedingly dangerous.

Winston Churchill, after all, was a wretched speller.

Theodore R. Sizer is acting principal of the Francis W. Parker Charter School in Devens, MA; university professor emeritus, Brown University, Providence, R.I.; and chairman of the Coalition of Essential Schools. Sizer has authored numerous books on education reform, including *Horace's School: Redesigning the American High School* (Houghton Mifflin, 1992) and *Horace's Hope: What Works for the American High School* (Houghton Mifflin, 1996).

Suggested Reading

In the hefty and controversy-laden literature on educational assessment, a good place to start is with Grant P. Wiggins, *Assessing Educational Performance* (Jossey-Bass, 1993) and Linda Darling-Hammond, *The Right to Learn* (Jossey-Bass, 1997). The National Center for Fair and Open Testing (342 Broadway, Cambridge, MA 02139) is a useful watchdog and commentator on assessment policies and practices. Its quarterly publication, *FairTest Examiner*, is a ready source of up-to-date information. See also Howard Gardner, *Frames of Mind: The Theory of Multiple Intelligences* (Basic Books, 1983).

— Theodore R. Sizer, Ph.D.

Campus drinking
from page 1

found that while students retain the information they have learned about drinking, it doesn't affect their actions.

Binge drinking

The general literature has defined "binge drinking" as consuming five or more drinks in a sitting. The number of drinks may be lowered to four for females, because of their lower tolerance for alcohol. But this definition has been criticized for its arbitrariness, and its lack of a time factor. However, David Anderson, Ph.D., of George Mason University in Fairfax, Va., says "Binge drinking has no time restraint. Five drinks in five to six hours is not what we're concerned about." Since the body can metabolize about a drink an hour, such an amount, especially if taken with food, would not necessarily lead to a high level of intoxication, says Anderson. The real problem is students drinking that much within an hour, or drinking 15 to 25 drinks over the course of an evening, he says. Anderson is co-author of the sourcebook, *Promising Practices: Campus Alcohol Strategies.*

Rob, a non-residential student at Bridgewater State College in Massachusetts, says he drinks heavily — eight to 12 drinks over two hours — about twice a month, and has blacked out. Of his alcohol education from high school, Rob says, "I didn't care then, I don't care now." He is concerned, however, about becoming an alcoholic, like some of his family members.

"I learned in a class that thinking about your next drink is a sign of alcoholism," he says. "As long as I feel I don't think about it all the time, I think I'm okay."

Why programs fail

It is, in part, this attitude among students that makes it so hard for universities to regulate drinking on their campuses. Education and fear tactics generally do not work because students *want* to drink. Whether students drink to fit in, to explore or just to engage in a fun social activity, intervention efforts will fail if they do not take this factor into account, according to Michael Haines, M.S., coordinator of health enhancement services at Northern Illinois University in Dekalb.

Social marketing, also called a 'normative media campaign,' endeavors to change the campus culture regarding alcohol.

"Students show a high degree of support for policies that concur with their normative beliefs," Haines says. "People like to drink, but they don't like it when people vomit in their bathrooms. They will support policies that crack down against problem behaviors, but [that still allow them to] drink."

Haines' efforts aim not to eliminate alcohol use completely, but to reduce it to moderate, safe levels. Instead of forbidding alcohol, he provides students with information on why not to drink, but also on how to reduce risks if they are going to drink.

Campus policies must be chosen carefully, because evidence shows that a poor policy will — at best — be mocked by students, and at worst actually may increase danger. Zach at the University of Virginia says students mocked and tore down anti-drinking posters on campus because the posters were "really bad."

Alex, a sophomore at the University of Virginia, finds fault with the school's policy against drinking in residence halls. "I think it's a little bit silly that they don't let people drink in dorms," he says. "From what I heard, the people in Virginia who died were hurt coming home."

Haines agrees, saying, "I think the safest place on campus [for drinking] is residence halls. Policies just change the location, not the behavior."

Social marketing

In response to the failure of traditional interventions, James Turner, M.D., head of student health services at the University of Virginia, says his school is turning to a "social marketing" approach, modeled after programs already in effect at some schools, including Northern Illinois University and the University of Arizona. Social marketing, also called a "normative media campaign," endeavors to change the campus culture regarding alcohol. This is done by providing students with information about other students' drinking habits. Some research indicates that students who do not drink much themselves, but think that everybody else does, are far more common than are the actual heavy drinkers. Although perceptions of student drinking are high, actual drinking is in fact at a 17-year low, according to the annual Monitoring the Future

Study led by Lloyd Johnston at the University of Michigan in Ann Arbor.

This difference between perception and reality may contribute to an atmosphere in which binge drinking is acceptable. By correcting their perceptions and showing them that most students do not engage in binge drinking, program administrators hope to make such behavior less "normal," and therefore, less common.

Johannessen uses the term "lock-in" for this phenomenon, which refers to the concept of increasing returns. "The more you see something happening, the more you think there is," she says.

The social marketing approach is having some success. Before the campaign at Northern Illinois University started 10 years ago, students thought that 70 percent of their peers were binge drinkers. The actual percentage was in the 40s. In the 10 years since the social marketing campaign was begun, binge drinking on campus has been reduced 44 percent, and alcohol-related injuries to others have dropped by 76 percent.

Through an extensive media campaign including posters, advertisements in the campus newspaper and monetary rewards for those who know the correct statistics, student perceptions of drinking have become more accurate. Students initially express surprise and doubt about the veracity of the statistics. "When you look at [the posters] you're like, 'People really drink that little?' Then you think and realize that you don't usually see many people drinking more," says Jamie, a senior at Northern Illinois University.

Social marketing's effectiveness is consistent with students' perceptions of the situation. While no student interviewed for this article had ever felt direct peer pressure to drink, some did report that sometimes social situations such as parties — where students are "supposed" to drink — create pressure. By highlighting the fact that most students in such situations do not binge drink, some of the social pressure may be lifted.

Changing social norms is, however, somewhat limited in its scope, in that it is only useful for relatively moderate drinkers. Students who drink excessively or who are in fraternities generally know their level of drinking is abnormally high, according to Johannessen. Social marketing strategies will not affect these students. ■

Jordana Haspel is a recent graduate of Brown University.

In case you haven't heard ...

Abercrombie & Fitch's newest quarterly magazine/catalog included selections such as a "Woo-Woo" and a "Brain Hemorrhage." They're not the latest back-to-school fashions; they're recipes for alcoholic concoctions that the retailer said were ideal for drinking games. Now the company admits it may have gone too far in its "Drinking 101" article, which encouraged college students to engage in "creative drinking" as an alternative to the standard beer bash. In response to reactions of outrage from groups such as Mothers Against Drunk Driving, Abercrombie & Fitch has said it will delete the article from unsold copies of its publication and issue a letter of explanation to readers.

Source: *Alcoholism and Drug Abuse Weekly*, Aug. 3

Youth and alcohol — key facts

- ✓ Approximately 10 million American youths under age 21 drink alcohol.
- ✓ The average age when 12- to 17-year-olds say they first tried alcohol is 12.8 years old.
- ✓ Although it is illegal for virtually all secondary school students to purchase alcoholic beverages, 81 percent of 12th graders have tried them at least once, along with 71 percent of 10th graders and 55 percent of eighth graders.
- ✓ Each year, junior and senior high school students drink an estimated 35 percent of all wine coolers and about 1.1 billion cans of beer.
- ✓ The typical American youth will see 100,000 beer commercials before age 18.
- ✓ Almost two-thirds (or 6.9 million) of junior high and high school students who consume alcohol purchase their own beverages.

Source: American Medical Association Office of Alcohol and Other Drug Abuse

Guest Commentary

Students are seeking to gain an academic edge with Ritalin

By Carol Lewis, M.D.

As a pediatrician who has the privilege of caring for adolescent and college age students, I watch the annual excitement of a new academic year give way to high anxiety during exam week. The usual stress-related illnesses — insomnia, gastric distress, increase in colds and other infections — is always evident at this time.

The increase in the number of student requests for stimulant medication, most commonly methylphenidate (Ritalin), during exam time has *not* always been as evident. Usually these requests come from students who have already been evaluated and diagnosed with attention-deficit/hyperactivity disorder (ADHD).

Particularly striking was one industrious young man who came the week before exams requesting a prescription for Ritalin. He confidently asserted that he always uses it prior to exam week to maximize the effectiveness of his studying. When asked about his grades, he boasted of being able to earn A's or B's without the use of medication — but Ritalin provided extra assurance of stellar performance on papers and exams.

Diagnosis still evolving

What is ADHD? The definition is amorphous when observed over time and has undergone significant changes over the last 50 years. What has been termed "minimal brain damage," "minimal brain dysfunction," "hyper kineses" or "hyperactive child syndrome" has evolved into what we now refer to as attention-deficit/hyperactivity disorder. ADHD manifests itself as a constellation of symptoms. It begins in childhood, is persistent over time, pervasive across different settings and causes functional impairment. Diagnosis is strictly clinical. There are no laboratory tests or screening devices for the presence or absence of ADHD. ADHD is not defined at the etiological or pathological level. The definition or diagnosis may even be less tangible when applied to young adults because ADHD has not been studied as systematically in young adults as in children. Definition and diagnosis will continue to evolve along with our understanding.

As uncomfortably vague as this diagnosis may seem, every practicing pediatrician has witnessed the typical nine-year-old boy with ADHD who is failing miserably at school, is ostracized by his peers and whose parents are ready to disown him because of his impulsive, explosive disorganized behavior at home. We have witnessed the dramatic change attributable to the use of stimulants. The power of pharmacologic treatment cannot be over-estimated when one observes this same troubled child blossoming into a thriving youngster, performing well academically and socially, not doomed to a life of failure. This experience can be truly awe-inspiring. No wonder Ritalin is often thought of as a wonder drug.

When we witness such a miracle treatment, it's natural to want to extend its use and to reproduce its efficacy in other situations. A similar case occurred in pediatrics in the 1980s with the advent of the ability to treat children who have growth hormone deficiency with actual growth hormone. Dramatic results ensued — albeit with a price-tag well above $10,000. Children who otherwise would have had extremely stunted growth attained close to normal adult heights. But soon endocrinologists' offices were bustling with short parents who, having heard of the wonder drug, were bringing in their short sons (not growth hormone deficient) seeking a "cure" for their boys' short stature.

Too much emphasis on perfection

There has been tremendous pressure over the last several decades for children to perform well academically. Preschoolers are asked to know their alphabet before starting kindergarten. Pressure continues throughout the years and into college. No one wants to be short and no one wants to be a B student. Imagine a student asking a physician for stimulants or steroids prior to athletic competition. Such a request would most certainly be denied because we have appropriately seen fit to banish these practices. But might the use of stimulants to improve or provide a perceived edge academically be analogous to the use of drugs to maximize athletic performance? A person without ADHD, if given stimulants, can also experience a "good response" and find himself working more effectively.

When is medication appropriate and when should we expect that students use intelligence and cognitive controls rather than stimulants to attain superior performance? The desire among professionals to provide a "cure" and the emphasis we place on perfection are powerful forces that may, if not monitored, steer us into inappropriate treatment of academic "difficulties." ■

Carol Lewis is a clinical instructor in pediatrics at Brown University School of Medicine in Providence, R.I.

ISSN 0898-2562

The Brown University Child and Adolescent Behavior Letter

Monthly reports on the problems of children and adolescents growing up.

Parenting

'Time out' to correct misbehavior may aggravate it instead

By Peter Ernest Haiman, Ph.D.

For generations, parents have sought a reliable and dependable way to handle childhood misbehavior. One of the most recent techniques is time-out. Although time-out is better than spanking, it is not an appropriate way to deal with misbehavior, as it may create subsequent childhood behavior problems that can affect a child's well-being and severely strain the parent-child relationship.

Cries and misbehavior from children and adolescents are very much like a sore throat, aching muscles or a fever. All are symptoms. All have causes.

Behaviors are symptoms

Children's behaviors are determined, for the most part, by how children feel about the current state of their physical and psychosocial needs. Children feel these needs strongly, and are, by nature, quite sensitive to them. If one or more of their needs are not met, children will soon feel uncomfortable.

When children feel uncomfortable, they cry. Infants' and toddlers' cries announce their feelings of frustration. These cries have evolved as a survival mechanism. They attract parental attention. The purpose of a cry is to obtain the kind and quality of parental love and care that will properly attend to unmet needs and, therefore, establish feelings of security in the child. Older child and adolescent misbehavior serves the same purpose as the baby's cry — it announces that needs are frustrated.

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Inside This Issue

Childhood abuse is a risk factor for adolescent psychiatric disorders.
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Putting children to sleep on their backs has reduced rates of SIDS.
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Commentary: A timely look at the process of moral development and shame.
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This month's client handout: **Techniques for helping family members control anger.**

Eating Disorders

Study of SSRIs and anorexia nervosa yields disappointing results

By Theresa Waldron

A recently published study on the use of fluoxetine (Prozac) to treat anorexia nervosa indicates that the drug did not significantly improve the clinical outcome of patients in a structured inpatient program. The results are frustrating, say eating-disorders specialists, because there are no medications available specifically to treat anorexia nervosa. However, it appears that persons with anorexia who increase their body weight may be helped by fluoxetine and other selective serotonin reuptake inhibitors (SSRIs).

The study was a randomized, placebo-controlled, double-blind seven-week study of 31 women with anorexia nervosa who were receiving treatment on a clinical research unit. The women received individual psychotherapy three to five times weekly that included both supportive and cognitive-behavioral elements. They also attended group treatment sessions and participated in a structured behavioral treatment program aimed at normalizing eating behavior and weight. For ex-

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The Brown University Child and Adolescent Behavior Letter

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Professor Emeritus of Psychology, Medical Science, and Human Development at Brown University

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The Brown University Child and Adolescent Behavior Letter (ISSN 0898-2562) is published monthly by Manisses Communications Group, Inc., 208 Governor St., Providence, RI 02906, (401) 831-6020, fax (401) 861-6370, e-mail: lwjackim@manisses.com. Yearly subscription rates are $177 for institutions and $117 for individuals. Periodicals postage at Providence, RI. POSTMASTER: Send address changes to: Manisses Communications Group, Inc., P.O. Box 9758, Providence, RI 02940-9758. ©1998 by Manisses Communications Group, Inc. Member, Newsletter Publishers Association. **The Brown University Child and Adolescent Behavior Letter** reports monthly on work in child development. Our purpose is to provide timely, accurate information by drawing on professional journals, expert opinion and the experience of our editors and guest writers. **The Brown University Child and Adolescent Behavior Letter** does not offer medical, legal or administrative services and we encourage subscribers to seek advice from qualified professionals. **The Brown University Child and Adolescent Behavior Letter** is available in reference systems produced by Information Access Company. For more information, contact Information Access Company, Rights & Permissions Dept., 362 Lakeside Drive, Foster City, CA 94404, or call (800) 227-8431 (U.S. only) or (415) 378-5000. All rights reserved. Reproduction forbidden without the consent of the publisher. Authorization to photocopy articles for internal or personal use or the internal or personal use of specific clients, is granted by Manisses Communications Group provided that the fee of $6.00 per article is paid to the Copyright Clearance Center, 222 Rosewood Drive, Danvers, MA 01923, (508) 750-8400.

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Printed in USA

Keep Your Eye On

... discharging newborns.

Hospital discharge criteria for high-risk newborns may be inadequate, according to the American Academy of Pediatrics (AAP). Traditionally, discharge criteria have been based on a preset weight, usually five to five-and-one-half pounds. But a new policy statement from AAP says a single set of criteria for discharge isn't enough, and that individualized planning and physician judgment should determine discharge. The statement identifies four categories of high-risk infants, from a preterm infant requiring technological support to an infant whose irreversible condition may result in early death. "The final decision, which is the responsibility of the attending physician, must be tailored for the unique constellation of issues posed by each situation," the AAP policy states. (*Pediatrics*, August 1998. For more information, contact Heather Cunningham, AAP, 141 Northwest Point Blvd., Elk Grove Village, IL 60007-1098; (847) 981-7131.)

... autistic behaviors.

The new antipsychotic drug risperidone (Risperdal) may reduce some of the symptoms associated with autism, such as aggression, repetitive behaviors and irritability, according to a new study from the Indiana University School of Medicine in Indianapolis. Previous studies with older antipsychotic medications had shown improvement in symptoms linked to autism, but those drugs tended to have unpleasant side effects such as involuntary muscle movements. Risperidone, one of the newer class of antipsychotics, is far less likely to cause such side effects, although subjects experienced some mild sedation during the early part of the study. Although risperidone did reduce aggression and improve some other behaviors in the 31 tested children with autism, it did not improve their social relationships or use of language. (*Reuters*)

... new evaluation tool.

A new measure called the Parents' Evaluations of Developmental Status (PEDS) helps providers carefully elicit and interpret parents' concerns about their children's developmental problems. PEDS assigns probability of delays and disabilities to parents' worries, thus enabling clinicians to make evidence-based decisions about whether children need referrals, screening, counseling or other services.

PEDS, which uses 10 questions, was validated and standardized on 971 children. Its accuracy in detecting common disabilities ranged from 70 percent to 80 percent. Most false-positive results tended to be on older children who performed below average on intelligence, academics and language. (For more information, contact Page Glascoe, Ph.D., Associate Professor of Pediatrics, Vanderbilt University Medical Center, 426 Medical Center South, Nashville, TN 37232-3573; phone (615) 936-0249, fax (615) 936-0256.

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What's New in Research

Abuse increases risk of mental disorders

Investigators from North Shore University Hospital in Manhasset, N.Y., found that physical abuse functions as a risk factor for adolescent psychiatric disorders after other important known risk factors are taken into consideration.

Ninety-nine adolescents ages 12 to 18 who had documented evidence of physical abuse were recruited from the New York State Department of Social Services. Those youths were compared to 99 non-abused adolescents who were matched for age, sex, race and community income. The researchers performed diagnostic interviews and measures of selected risk factors for psychopathology to the adolescents and their parents.

They found that physical abuse added significantly to other known risk factors that account for diagnoses such as major depression, conduct disorder and drug abuse.

"Our findings highlight the importance of increased identification of physically abused adolescents so that mental health and substance abuse services can be provided," the authors conclude.

Kaplan SJ, Pelcovitz D, Salzinger S, et al.: Adolescent physical abuse: Risk for adolescent psychiatric disorders. *American Journal of Psychiatry* 1998; 155:954-959. For reprints, contact Sandra J. Kaplan, M.D., Department of Psychiatry, North Shore University Hospital, 300 Community Drive, Manhasset, NY 11030.

Supine position may reduce SIDS incidence

In a survey of 1,000 caregivers of infants, rates of sudden infant death syndrome (SIDS) declined significantly among infants who were placed supine instead of in the prone position to sleep. The survey took place from 1992 to 1996. In 1992, 70 percent of infants were placed in the prone position, prior to the recommendation from the American Academy of Pediatrics that infants be placed in a supine position to help prevent SIDS. By 1996, only 26 percent of infants were being placed in a prone position.

Between 1992 and 1996, SIDS rates declined by about 38 percent. Although causality cannot be established definitively, the researchers state there probably is a correlation between a decrease in SIDS and an increase in the number of infants placed in a supine position. They recommend that more reductions in SIDS could be accomplished by promoting a supine sleeping position among caregivers at high risk for placing infants in a prone position. In the study, those high-risk caregivers were more likely to be African-American, younger than 29, living in southern or mid-Atlantic states and having had a previous child.

Willinger M, Hoffman HJ, Kuo-Tsung W, et al.: Factors associated with the transition to nonprone sleep positions of infants in the United States. *Journal of the American Medical Association* 1998; 280: 329-335. For reprints, contact Marian Willinger, Ph.D., National Institute of Child Health and Human Development, Center for Research for Mothers and Children, Pregnancy and Perinatology Branch, Executive Building, Room 4803, 6100 Executive Blvd., MSC 7510, Bethesda, MD 20892-7510. E-mail: mw75q@nih.gov.

Misbehavior
from page 1

Cries and misbehavior from children and adolescents are, in a way, very much like a sore throat, stuffed-up nose, aching muscles or a fever. All are symptoms. All have causes. A medical practitioner knows that when the virus or bacteria that is causing physical symptoms is eliminated, the noxious feelings will be quelled. Similarly, when parents correctly diagnose and provide remedies that address the needs of children and adolescents, the symptoms of crying or misbehavior will also disappear.

Unmet needs can be uncomfortable at any age, but it is more so for children due to their dependent nature. Young children lack the ability to meet their own needs, and until a certain age, are physically unable to do most self-care tasks. Their often intense outbursts stem from this frustrating dependency, coupled with their inability to tolerate frustration well. In addition, infants, toddlers and many preschool-aged children are unable to identify the frustrated needs that are making them upset. This makes it impossible to tell their parents what is bothering them.

Time-out increases frustration

When time-out is used, parents first firmly demand that their child stop misbehaving and be quiet. The child is usually required to go and sit alone in a room, away from parents, and is admonished not to come out of the room until he is sure he can control his behavior. Being placed in

time-out prolongs the time that a child must endure the frustrated need that caused the misbehavior. Thus, unmet normal needs become increasingly uncomfortable as the time-out continues.

The fact that the child must be alone and away from the parents he or she depends upon, wants to be with, loves and relies on, exacerbates this increasingly uncomfortable state of being frustrated. Moreover, being alone in time-out can create additional disturbing feelings that the child must endure, such as fear and worry.

A frustrated child who must sit quietly and alone in time-out frequently becomes angry. Although they dare not express this anger when in time-out, children often express it by becoming angry and defiant sometime after being released from time-out.

Frequent time-out has lifelong effects

For the frustrated and uncomfortable child, time-out offers enforced silence and the feeling of being rejected by one's parents. A youngster who misbehaves and then is given time-out feels hurt, which, combined with the frustration that caused the youngster to misbehave, gives birth to anger. Discipline practices that create hurt and anger can harm a child.

Time-out sends the message that one should bottle up uncomfortable emotions. Children desperately need to stop the painful feelings going on inside them when they are upset in time-out and unable to express these feelings. To cope, they learn to ignore and/or distract themselves from the energy of their hurt and angry feelings, and thus, they learn to repress them. In the process, nervous habits emerge, such as thumb sucking, fingernail biting, hair pulling, skin scratching, tugging at clothes, self-pinching and many other similar behaviors. These behaviors serve to ward off uncomfortable feelings and, in identification with their parents' criticism, to punish themselves. Such defense strategies also serve to release anger and ignore uncomfortable feelings.

A youngster who misbehaves and then is given time-out feels hurt, which, combined with the frustration that caused the youngster to misbehave, gives birth to anger.

As a result, being unaware of true feelings often can become a characteristic feature of a person's life. This reduces a person's self-awareness and can affect the quality of life forever.

Developing the well-behaved child

Interpersonal dilemmas and conflicts are best resolved when each individual has sufficient opportunity to talk to and be heard by the other person. Modeling, initiating and practicing the process of open dialogue is essential if a youngster is to learn healthy problem-solving. Helping children talk about how they feel, combined with parental patience, is required if children are to develop the ability to verbalize their feelings and needs rather than act them out.

Parents can develop a well-behaved, self-disciplined child best by responsively and continuously meeting their child's developmentally normal needs and drives; by demonstrating and articulating humane values in day-to-day interactions with their youngster; and by exposing their child to life experiences that strengthen and reinforce these values. Parents who do not meet their child's normal needs and drives consistently and appropriately create troubled and spoiled children.

When children are physically healthy, well-nourished, satisfactorily exercised and not tired, their basic normal physical needs are being met. Their social and emotional needs are fulfilled when they receive sufficient and continuous satisfying attention, affection and recognition from parents and other adults and children to whom the child is emotionally at-

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The Jabberwocky Technique can help control your family's anger

by Jerry Wilde, Ph.D.

Anger is a normal human emotion and, as such, there is nothing inherently bad about or wrong with anger. It is an emotion that can motivate people to stand up for themselves, move beyond apathy or take any number of positive actions. On the other hand, anger can become out of control and counter-productive. Once again, there's nothing wrong with anger. It all depends on what people do with it.

Anger in families

Anger in families can shut down communication rather than foster it. Very little gets resolved when discussions turn into screaming matches. It is with that in mind that the Jabberwocky Technique is introduced. This intervention is typically used with families in which explosive anger is a common problem.

Perhaps the best way of explaining the Jabberwocky Technique is through an example. Let's say a couple is discussing the latest phone bill, which is higher than usual. The man is very upset at the length of calls to the woman's best friend in California. The woman states that she saves money in other ways and thinks of her long distance calls as a form of entertainment. She points out that, unlike him, she doesn't spend money on

Helping children deal with anger

What follows is an example of how rational-emotive imagery (REI) or the "make believe game" can be used with children and adolescents who have anger problems.

Start by having the child vividly describe an anger-producing scenario. Get as many details as possible about the sights, sounds and events in this situation. Then have the child get as relaxed as possible in her chair with both feet on the floor.

Parent: *Amy, I want you to listen very closely to what I'm going to tell you. I want you to only be aware of my voice and focus on what I say. Try to block everything else out of your mind for the time being. Imagine you are back in your class having problems with Mr. Smith. Picture the room in your mind. See all the posters on the walls and everything else that is in your class. Now go ahead and let yourself feel like you did that day. Feel all the anger you felt back then. Stay with that scene and try to feel just like you felt in the class. When you feel that way, wiggle your finger and let me know you're there.*

(Author's note — It's a good idea to look for behavioral signs confirming that the child is actually feeling angry. The jaw may tighten, brows furrow and some children even make fists.)

Stay with that feeling. Keep imagining that you are in your classroom.

(Author's note — Allow the child to stay in this state for approximately 20 to 40 seconds. Remind her to mentally stay in the situation and to remain upset.)

Now I want you to keep thinking you are in the class, but I want you to calm yourself down. Stay in the classroom in your mind but try to calm down. Instead of being very upset, try to get calmer. Instead of being really mad, try to work toward only feeling irritated. Keep working at it until you can calm yourself down. When you can make yourself calm, wiggle your finger again.

Usually children can reach a state of relative calm within a fairly short period of time. Once the child has wiggled her finger, it is time to bring her back to the here and now. Simply say something like, "OK, now open your eyes." Next ask, "What did you say to yourself to calm yourself down?" If the child was able to calm herself down, she had to be thinking rationally. If the exercise doesn't work, try it again, encouraging the child to keep imagining the scene while working to calm down.

After completing REI, children should then be able to tell you the thought that allowed them to calm down. A typical calming thought that might have been produced from the above scenario would be, "Even though I don't like the problems I've been having with my teacher, I can live with it. I don't have to like what he does."

Once the child has practiced a calming thought, write it down. Now he can practice this mental imagery using the same thought several times a day. This technique allows children to mentally practice dealing with difficult situations in new, productive ways. It's important that they practice this make believe game on a regular basis if they are going to learn to handle their anger in a more productive fashion.

fishing tackle that actually costs more than her weekly calls to her friend. The man points out that his fishing also helps to feed the family. This type of verbal sparring goes back and forth. Voices start to get louder as the discussion turns from the phone bill and starts to become personal. The couple's son is feeling the tension as the argument is getting more heated. Sound familiar?

"Jabberwocky"

At this point, when things are starting to get out of hand, something needs to be done to contain this discussion. The Jabberwocky Technique is used in this capacity as a means of interrupting arguments that are getting out of control. It works like this:

At any point in an argument, any family member can call a code work (such as "Jabberwocky"), and the argument is to stop for the time being. Think of it as a verbal "cease and desist" order. The family is usually wise to give each other some space and time to calm down before resuming the discussion.

Prior to this plan being implemented, the family establishes the amount of time needed to cool off. Some families heat up quickly and calm down just as fast. Others are slow boilers and need to take a few hours before revisiting the original discussion. One of the rules is that all family members agree to examine the topic again after things have cooled down.

Trouble shooting

There are a number of ways in which such a plan can be sabotaged. First, unless everyone in the family agrees, it is very difficult to make this plan work. Family members will say, "I'm not going to do it unless Dad agrees, too."

Another problem has to do with the actual compliance. Some family members will give verbal consent to the Jabberwocky Technique, but in the heat of an argument will refuse to cease and desist. They will just keep arguing. It's hard enough for some family members to walk away from an argument, but it's especially difficult if the other person keeps talking.

One of the ways of limiting this type of noncompliance is to ask the family members in advance which person is most likely to disregard this rule. If all members single out a family member, it makes it much less likely that member will actually violate the rule. People do not like it when family members can predict their behavior. When the entire family says, "Our mother will keep right on talking," chances are that Mom will behave in a way that will not allow the family to be right.

Another means of sabotaging this plan is to use the technique as a means of shutting down communication about certain topics. For example, every time the topic of purchasing a new car is even mentioned, one family member calls out, "Jabberwocky."

The best way to ensure this will not happen is to use the same procedure as above. Ask the family which member is likely to use this program as a means of shutting down communication. The same dynamic applies. The likelihood of that person actually behaving in that manner is diminished considerably.

Dr. Wilde is a professor of educational psychology at Indiana University East. He has conducted conferences on anger management nationwide and is the author of numerous books including *Anger Management in Schools: Alternatives to Student Violence* and *Treating Anger, Anxiety and Depression in Children and Adolescents: A Cognitive Behavioral Perspective*.

The Brown University **Child and Adolescent Behavior Letter**

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tached. If a child's normal curiosity, exploratory nature and intrinsic interests are regularly allowed opportunities to unfold and develop, the intellectual needs of that child will be satisfied. When young children are given opportunities, within a securely supportive and trustworthy environment, to become increasingly more independent, make choices and meaningfully participate in decision-making, their normal need to exercise some control over their life and to express their own will are being appropriately addressed.

It's very important for parents and parents-to-be to learn the developmentally normal characteristics of each stage of early human development. It's also important to recognize a virulent myth that still exists in our society: that fully meeting a child's needs will spoil the child. The research literature clearly says that the opposite is true. The well-disciplined child is created when parents appropriately fulfill the needs of childhood and adolescence. ■

Dr. Peter Ernest Haiman was tenured chairman and associate professor of a department of early childhood education at the University of South Carolina. He is author of the Parent Involvement Performance Standards for the National Head Start program. For over two decades, he has been a consultant to Head Start programs throughout the country. He is a therapist and child-rearing counselor. He may be reached by phone at (510) 527-6436, or by e-mail atajpa@pacbell.net. A version of this article was published in the May-June issue of *Mothering*.

Anorexia nervosa

from page 1

ample, in the weight gain phase of the program, patients were given a prescribed number of calories and were expected to gain at least one-and- a-half pounds weekly until they reached 90 percent of their ideal body weight. If patients didn't gain enough weight, they were prescribed extra calories and remained on bedrest until their weight gain resumed.

At the end of the study, investigators found no significant differences between patients receiving 60 mg of fluoxetine daily and those receiving placebo.

"The field has been interested in finding a medication that might help these patients," says Evelyn Attia, M.D., director of the general clinical research unit of the New York State Psychiatric Institute in New York City and lead author of the study. "There seems to be something so biologic about what happens to these young women in that all their stories sound so precisely the same. Certain neurochemical disturbances have been noted. Between the combination [of those factors], we felt that there has got to be a pharmacologic agent that can be helpful."

Fluoxetine for bulimia

Attia and her colleagues looked at fluoxetine in particular because it has been found helpful in treating bulimia nervosa; the drug is approved by the Food and Drug Administration for bulimia nervosa, depression and obsessive-compulsive disorder. In addition, many underweight patients with anorexia appear to be depressed. There also are many compulsive behaviors associated with anorexia, such as rituals and mental preoccupations.

She speculates that one reason fluoxetine may not have caused improvement in the women was that low body weight associated with anorexia causes neurochemical disturbances, particularly in the level of the major metabolite of serotonin, 5-hydroxyindoleacetic acid (5-HIAA). A drop in the level of the 5-HIAA metabolite appears to interfere with the ef-

Recommended Reading

THE BATTERED CHILD (5TH EDITION) — *M.E. Helfer, R.S. Kempe and R.D. Krugman. Chicago: The University of Chicago Press. 694 pages, $45 (hardcover), 1997. (800) 621-2736.*

ADOLESCENT BREAKDOWN AND BEYOND — *M. Laufer. Madison, Conn.: International Universities Press. 156 pages, $27.50 (hardcover), 1998. (800) 835-3487.*

ASSESSMENT OF CHILDHOOD DISORDERS (3RD EDITION) — *E.J. Marsh and L.G. Terdal, Eds. New York: Guilford Publishing Inc. 800 pages, $75 (hardcover), 1997. (800) 365-7006.*

TRAUMA, DISSOCIATION AND IMPULSE DYSCONTROL IN EATING DISORDERS — *J. Vanderlinden and W. Vandereycken. Bristol, Pa.: Brunner/ Mazel. 225 pages, $28.95 (hardcover), 1997. (800) 825-3089.*

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fects of fluoxetine. Because persons with bulimia tend to have normal or near-normal body weight, they don't experience those same neurochemical changes, says Attia, so they are more likely to respond to the drug.

"Once you've normalized weight, patients may be capable again of responding to the medication," she explains. "[But] there's certainly no evidence, based on our study, for using [fluoxetine] or any pharmacologic intervention in the significantly underweight patient."

Fluoxetine may be effective in preventing relapse among persons with anorexia, however, according to Walter Kaye, M.D., professor of psychiatry and director of the Eating Disorders Program at the University of Pittsburgh. In a study he presented at last year's American Psychiatric Association annual meeting, 35 persons with anorexia who had undergone inpatient weight restoration received either placebo or fluoxetine. Sixty-three percent of fluoxetine patients maintained weight gain compared to 16 percent of placebo patients. (See *Psychopharmacology Update* July 1997, p. 7.)

But Kaye agrees with Attia that the SSRIs probably aren't helpful in very underweight patients.

"We know there is a large difference in serotinergic activity between the underweight state and the recovered state," Kaye says. "We have data too suggesting that these medications don't work when people are underweight."

Slight weight gain may be helpful

But at what weight do SSRIs become effective in persons with anorexia? James E. Mitchell, M.D., professor and chairman of the department of neuroscience at the University of North Dakota and president of the Neuropsychiatric Research Institute in Fargo, says that even modest weight gain among persons with anorexia may make them more responsive to SSRI therapy.

"We know when anorexics gain relatively modest amounts of weight, there are a number of physiologic changes that come back right away," he says. "That raises the question of when serotonin reuptake inhibitors may be effective for them. We don't know that yet. But I think if patients are very, very skinny, [SSRIs] probably don't work. When they're getting near their normal weight, they probably do work. But where the line is between those two [situations] isn't clear."

"There is a large difference in serotinergic activity between the underweight state and the recovered state."

— Walter Kaye, M.D.

Mitchell adds that increasing weight in persons with anorexia is an important aspect of their psychological recovery, despite their inability to respond to SSRIs.

"Many times, when anorexics gain even five to 10 pounds, psychologically they change fairly dramatically," he says.

Mitchell says he doesn't treat many very low-weight anorexic patients because the facility he directs doesn't have an inpatient unit. He does prescribe SSRIs on an outpatient basis for persons with anorexia who are working toward normalizing their weight or who have already normalized their weight, and that the drugs do appear to be effective in that group of patients.

Other drugs may be appropriate

For very underweight patients, Mitchell says he sometimes uses drugs other than SSRIs to help patients gain weight and feel better psychologically. For example, he occasionally prescribes cyproheptadine (Periactin), a serotonin inhibitor that has been shown in one study to improve the rate of weight gain in hospitalized persons with anorexia. He also sometimes prescribes gastric peristaltic agents such as cisapride (Propulsid), which stimulate gastric emptying into the small bowel.

"Anorexics have markedly delayed gastric emptying, and they have a lot of bloating when they eat," Mitchell explains. "Cisapride or other drugs like it are used in very low-weight anorexics who are having problems eating."

Another problem with persons with anorexia is insomnia. Mitchell says a drug that appears to help patients sleep is desyrel (Trazodone), although it's used in low doses (50-100 mg). He says some clinicians are also trying very low doses of new atypical neuroleptics such as olanzapine (Zyprexa) in some persons with anorexia.

"Particularly in very low-weight, semi-delusional anorexics where their concerns

about weight and body shape image disturbance are of psychotic proportions, [neuroleptics] are used in that situation," Mitchell says.

Kaye stresses that the latest study from the New York Psychiatric Institute does not mean that fluoxetine or other SSRIs should not be used in patients with anorexia nervosa. Although they don't appear to be as effective in very low-weight patients, the goal of any anorexic's recovery is weight gain. And once a patient's weight does increase, fluoxetine and other SSRIs are indicated.

"I hope this doesn't mislead people into thinking there isn't a role for SSRIs in the treatment of anorexia," he notes. "After weight recovery, [SSRIs] are efficacious." ■

Reported by Theresa Waldron, a freelance reporter based in Marietta, Ga.

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Commentary

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cal behavior omit consideration of the *processes* through which children acquire anticipatory shame — that capacity for anticipating what one is considering doing, weighing the possible outcomes of the behavior and acting on the thought process involved. Of this we can be fairly sure, however. The way one behaves in situations involving ethical dilemmas is rather context-specific. For example, a person who would not steal under ordinary circumstances may find it acceptable to do so to save the life of her child. A man who would not kill another under most circumstances may find it justifiable to do so in war.

Shame development always involves a training period in one's early life. The child "references" the parent to see if what he is about to do will be censured or will be rewarded. If the parent prohibits the behavior, the child learns this is a no-no. If the caretaker does not interfere, the child learns that it is permissible.

Sometimes the parent may say "no" while presenting a little smile. From the faint smile, the child may learn "it's a no-no but maybe I'll get away with it." In subsequent dilemmas, where the issue is whether the behavior is permitted or not, the child may manifest continuing confusions over what is permissible, and may not understand it when "the heavens fall" over something he does.

Most people compartmentalize; their behavior is frequently context-specific. While behaving acceptably most of the time, their behavior may not be appropriately socialized in a limited area. It is as if the brain does not appropriately censure or inhibit the behavior about to occur. Anticipatory shame is absent. And when misdemeanors are discovered in an area not protected by anticipatory shame, even the perpetrator's closest associates often express surprise.

Childhood patterns persist, and adults behave much like the children they were. This is not to say that early-acquired behaviors cannot be unlearned, or that new behaviors cannot be learned. But anti-social, egocentric, hedonistic behaviors are especially resistant to alteration. It is as if those early behavior patterns have served too well— have been rewarded too much — in getting the "deprived" child through the early part of his life.

In choosing our elected officials, as in choosing our surgeon, it is not possible to examine or to be authoritative about every aspect of that person's psychological functioning. We make our predictions, and place our bets, on the basis of the person's observed behavior, reputation and track record in the skills we require. We may not like it if the surgeon is verbally abusive toward his wife, or cheats on his income tax. But if he is the most skilled technician available for attending to our special need, few among us would pass up the opportunity to avail ourselves of the services of that person. ■

Lewis P. Lipsitt

Commentary

Shame: Children should not leave home without it

One might not think, when all is said and done, that there is anything left to say or do. But there is much to say about child training in connection with the perturbations currently sweeping this country. The nation's president has kept us on the edge of our seats. Never has there been so much talk about what a man should do in the throes of such a predicament as he finds himself.

Human development is complicated. Some aspects of it, however, are quite simple. Like the laws of gravity and fluid mechanics, the laws of learning are always in effect and are not nullified by unexpected or fortuitous events. The major principles of human development are always in place, although the complete story remains inexorably uncertain.

Humans come into the world with tendencies to behave in predictable ways under specific circumstances. Offer a newborn something soft around his face and he'll turn his head to grasp it. Pinch an infant on the arm or leg and she'll recoil and cry. Stroke an infant's skin with massage, and the baby becomes quiet, and may even look you in the eye with an expression you'll never forget.

These infantile behaviors are gifts of the species, generated initially by an intact nervous system when stimulated, and of great psychological importance in setting the stage for future development. That development is dictated in part by genetic changes in anatomy, physiognomy, neural tissue and hormonal function. Genetic determination is set at conception and (today) is essentially unalterable, but the genetic destiny of an organism can be changed drastically by environmental events such as accidents, diseases or homicide. Regardless of how we dub the polarities — heredity and maturation on one side, and the environment and learning on the other — both are 100 percent important. The built-in behaviors of babies are quickly altered by environmental conditions. Parenting and socialization make all the difference in the world. Within moments after birth, the newborn quickly learns to turn his head left or right depending on where the warmth and nipple are coming from. Later there will be other tasks to learn, and the teachers will be those most closely associated with and attached to the baby.

The superimposition of learned coping skills on species-specific talents, and the individual differences in these with which we come into the world, provide the core characteristics of what we call "personality." Among our acquired attributes are our concerns for our future, and our contemplation of our past.

Profoundly felt shame, which depends upon a sense of both the past and the future, is uniquely human. There is no shame without a personal history of attachment to at least one other person, whom we suppose will be disappointed in us if we misbehave.

Attachment requires some unpacking. In being cared for by loving, attentive, non-injurious people, the young child learns to trust some person or people. He or she looks to those people for guidance even before asking for it, for example, by gazing at the trusted person, often the mother, to see if what is going on is all right. This near-universal tendency, once acquired, is the root of attachment. If the child does become successfully attached, this pattern of dependency on others, with the associated talent of caring for other persons, generalizes to still others whom one also comes to trust.

The capacity to truly relate to other people is acquired early. If it is not acquired by the age of five years, the child may be destined for a life of tenuous associations with others, social isolation or even a downright aggressive disposition. Orphans in Eastern European institutions beyond the ages of five or six years, in the care of personnel who have taken little interest in them and may have harmed them physically, are extremely resistant to socialization even when adopted by caring, hopeful, indulgent parents. Many of these children are found, eventually, to have severe attachment disorders.

Children who grow up without developing loving, trusting relationships often have flaws in the capacity to feel shame when they have done something clearly contrary to what is accepted in their social environment. They frequently lack "anticipatory shame" — the capacity of understanding, in advance of their behavior, what the probable consequences will be. And once they have engaged in the unsanctioned behavior, they have difficulty understanding that others want them to feel remorse and express regret.

Most discussions of moral development and ethi-

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ISSN 0898-2562

The Brown University Child and Adolescent Behavior Letter

Monthly reports on the problems of children and adolescents growing up.

Substance Abuse

To prevent drug use, social factors must be addressed

By John J. Colby, Ph.D.

When people think about teenagers using drugs they often picture a person with a mental disturbance. But the facts of teenage drug use do not generally reinforce the perception of a disturbed kid turning to drugs. Most kids who use drugs are quite normal in most respects. If they do have problems, they are more often associated with their social circumstances, especially at home and at school, than mental disturbance, per se.

For most affluent high school kids, using drugs, especially alcohol, is the norm, not the exception. When asked, "Why do you drink a lot?" well-to-do teenagers are likely to say, "Why not?"

Well-to-do suburban kids are the most likely teenagers to use alcohol and marijuana, according to recent reports. Those kids are often involved in athletics and other school activities and typically they do well in their studies and appear to be happy and well adjusted. Their drug use, especially their tendency to binge drink, belies their otherwise normal development. So how do we explain their drinking and use of marijuana?

For one thing these kids have money and can buy drugs if they are so inclined. But why are they so inclined? First, for most affluent high school kids, using some drugs, especially alcohol, is the norm, not the exception. When asked, "why do you drink a lot?" well-to-do teenag-

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New approaches to treating overweight children includes parental involvement and positive reinforcement.
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Commentary: The societal dilemma of adolescent criminals.
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This month's client handout:
Surviving the holidays: Less stress for you and more fun for the whole family

Social Action

Arizona campaign effectively targets cinema smokescreen

By Brad Christensen

"Toys come to life. Dinosaurs roam the earth. Cigarettes are cool. Only in Hollywood."

This message is being delivered to theater-goers by a "cinema spot" that counters Hollywood's glamorization of tobacco.

Six different spots, also called on-screen billboards, have been developed by the Arizona Department of Health Services (ADHS) to run before movies in participating theaters. This summer the spots were showing on 401 screens at 50 theaters statewide.

One spot promotes a tobacco-cessation hotline by saying, "By the time this movie is over, you'll have been smoke-free for hours. We can help you stay that way." Other spots focus on cigars and pregnant women.

Tobacco has a starring role

Research reveals that tobacco has taken on a much greater role in the movies in the 1990s, particularly among young lead actors and actresses. One study found that by the mid-1990s more than three-quarters of all U.S. films

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The Brown University Child and Adolescent Behavior Letter

Editor: Lewis P. Lipsitt, Ph.D.
Professor Emeritus of Psychology, Medical Science, and Human Development at Brown University

Contributing Editors:

Stephen L. Buka, Sc.D., Associate Professor, Department of Maternal and Child Health, Harvard University School of Public Health

Cynthia Garcia Coll, Ph.D., Professor, Education, Psychology and Pediatrics, Chair of Education Department, Brown University

Ferdinand Jones, Ph.D., Professor of Psychology, Brown University, formerly director of Brown University Student Counseling

Dwight B. Heath, Ph.D., Professor Emeritus of Anthropology, Brown University

Carol Landau, Ph.D., Clinical Professor of Psychiatry and Human Behavior, Brown University, private practice

Carol Lewis, M.D., Clinical Instructor in Pediatrics, Brown University School of Medicine, private practice

Theodore R. Sizer, Ph.D., University Professor Emeritus, Brown University, Chairman, Coalition of Essential Schools, former director, Annenberg Institute for School Reform

Sally Zierler, D.P.H., Associate Professor of Medical Science, Brown University School of Medicine

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The Brown University Child and Adolescent Behavior Letter (ISSN 0898-2562) is published monthly by Manisses Communications Group, Inc., 208 Governor St., Providence, RI 02906, (401) 831-6020, fax (401) 861-6370, e-mail lwjackim@manisses.com. Yearly subscription rates are $177 for institutions and $117 for individuals. Periodicals postage at Providence, RI. POSTMASTER: Send address changes to: Manisses Communications Group, Inc., P.O. Box 9758, Providence, RI 02940-9758. ©1998 by Manisses Communications Group, Inc. Member, Newsletter Publishers Association. **The Brown University Child and Adolescent Behavior Letter** reports monthly on work in child development. Our purpose is to provide timely, accurate information by drawing on professional journals, expert opinion and the experience of our editors and guest writers. **The Brown University Child and Adolescent Behavior Letter** does not offer medical, legal or administrative services and we encourage subscribers to seek advice from qualified professionals. **The Brown University Child and Adolescent Behavior Letter** is available in reference systems produced by Information Access Company. For more information, contact Information Access Company, Rights & Permissions Dept., 362 Lakeside Drive, Foster City, CA 94404, or call (800) 227-8431 (U.S. only) or (415) 378-5000. All rights reserved. Reproduction forbidden without the consent of the publisher. Authorization to photocopy articles for internal or personal use or the internal or personal use of specific clients, is granted by Manisses Communications Group provided that the fee of $6.00 per article is paid to the Copyright Clearance Center, 222 Rosewood Drive, Danvers, MA 01923, (508) 750-8400.

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Printed in USA

Resources

Prevent child access to pornography with "SearchHound"

An Oklahoma-based company is offering a search engine for parents to reduce the number of adult-related listings available on the Internet. Called "SearchHound," the search engine was developed by Mark Joyner, chief operating officer of Bodhi Tree Corporation in Worcester, Mass., and by Web Genie Software in Australia.

By default, a SearchHound search will filter out sites that may include any number of words commonly associated with adult or any other potentially offensive sites. If a user searches for adult-related keywords or tries to search the database that includes adult listings, he or she must pass through a warning screen before being able to view the content. SearchHound is compatible with all available pornography-blocking software on the market, says Joyner. For more information, contact the Bodhi Tree Corp. at (580) 510-0450.

NASP offers guide on effective parenting

The National Association of School Psychologists (NASP) in Bethesda, Md., has published a position statement for parents, "Effective Parenting: Positive Support for Families." The guide offers concrete, practical ways for parents to prevent behavior problems in children, including developing a trusting relationship, setting limits and offering praise. The guide also offers research-based interventions to address disruptive behavior that involves both families and schools as they collaborate to meet the needs of the student. The guide was developed in conjunction with the Center for Effective Discipline in Columbus, Ohio.

To obtain a copy of the guide, contact Victoria Stanhope, NASP, 4340 East West Highway, Suite 402, Bethesda, MD 20814; (301) 657-0270, ext. 223.

Video helps students learn to succeed at work

For young workers in their first job, knowing what to do when things go wrong is critical, but is often neglected in their training for the working world. Sunburst Communications in Pleasantville, N.Y., has developed a video, "Trouble at Work," that focuses on dealing with situations for new employees in the workplace, such as how to take criticism and what to do if the boss behaves unethically.

The video presents a variety of real-life situations for students, such as a young man who puts his own job in jeopardy by covering the inappropriate behavior of a co-worker who also is good friend. The scenarios help students anticipate and recognize typical workplace problems, create strategies to deal with

the problems and become familiar with specific workplace environments such as the personnel department.

Other issues the video addresses include understanding what an employer expects beyond basic tasks and skills, and developing attitudes and abilities to help achieve success. The 32-minute video includes a teacher's guide with questions for discussion and suggested activities, such as role-playing. The cost of the video and teacher's guide is $99.95. For more information, contact Sunburst at 101 Castleton St., Pleasantville, NY 10570. Telephone: (800) 431-1934. E-mail: service@nysunburst.com or www.SUNBURST.com.

Improve conditions in juvenile jails

The U.S. Department of Justice (DOJ) has released a new publication to improve conditions for more than 110,000 jailed youths in juvenile detention centers and adult jails. The DOJ report notes that too many facilities lack adequate services such as health care and education, and are overcrowded and unsafe. Child advocates, parents and program administrators interested in easing those conditions may benefit from the publication, *Beyond the Walls: Improving Conditions of Confinement for Youth in Custody*, which outlines six methods for improving oversight, monitoring and services for detained and committed youths without resorting to litigation.

For more information, call the DOJ's Office of Juvenile Justice and Delinquency Prevention Clearinghouse at (800) 638-8736. Fax: (301) 519-5212. E-mail: www.ncjrs.org/ojjhome.htm.

Keep Your Eye On

... toppled television sets.

Alabama researchers report that toppled television sets caused 28 deaths among children from 1990 to 1997. In a retrospective analysis from the U.S. Consumer Product Safety Commission and the Children's Hospital of Alabama from January 1990 until October 1997, investigators found 73 cases that involved falling television sets, including 28 deaths. The average age of victims was 36 months, and the average age of those who died was 31 months. Young girls comprised 42 incidents (58 percent) and 19 deaths (68 percent). The most common site of injury was the head in 72 percent of cases; the remaining cases were classified as generalized crushing injuries.

The researchers warn that placing televisions on elevated locations is dangerous and that more attention should be paid to the safer design and placement of televisions in the home. (*Pediatrics*, September 1998. For more information, contact Philip A. Bernard, M.D., Division of Pediatric Critical Care, Department of Pediatrics, ACC506, 1600 7th Avenue South, Birmingham, AL 35233.)

... children's health insurance.

More and more states are joining the Children's Health Insurance Program (CHIP) plans sponsored by the U.S. Department of Health and Human Services. North Carolina, Utah, Indiana and Puerto Rico recently joined 20 other U.S. states and territories, which now offer health insurance coverage to 1.7 million previously uninsured children. Twenty-one other states have submitted plans to DHHS for CHIP programs. North Carolina is expected to enroll 35,000 children during its first year, and up to 21,000 children will be enrolled in Utah by the year 2000. Indiana will insure 58,000 children by 2000, and Puerto Rico will include 165,000 children in its CHIP plan by the end of this year. The plans are meant for children in low-income families who aren't eligible for Medicaid services. (*The Nation's Health*, August, 1998. For more information, contact the American Public Health Association, 1015 15th St. NW, Washington, DC 20005-2605; (202) 789-5600.)

... after-school snacks.

The U.S. House of Representatives recently voted to allow schools and community groups to use federal funds to provide a light meal to at-risk children ages 13 to 18 who participate in after-school programs. Currently, only children ages 12 and under are eligible for such programs. Proponents of the teen snack program say that schools and community groups have been financially strained to offer programs to keep teens off the streets after school. Providing food is one way to encourage at-risk teens to participate in sports and other programs. The program is an amendment to the National School Lunch Act and Child Nutrition Act of 1966.

Similar legislation is expected to pass in the Senate before Congress adjourns for the year. (*School Board News*, August 4, 1998. For more information, contact Ellen Teller, The Food Research and Action Center, 1875 Connecticut Ave., NW, Suite 540, Washington, DC 20009; (202) 986-2200.)

... ADHD drugs.

Supplies of two commonly used drugs to treat attention-deficit/hyperactivity disorder, dextroamphetamine/amphetamine (Adderall) and dextroamphetamine (DextroStat) may be in short supply in the coming months. Shire Pharmaceuticals Group in London reports that due to an explosion at one of its manufacturing plants in Somerville, NJ, supplies for making the two drugs have been temporarily cut off. However, the company says it has enough supplies of the drugs to meet the needs of existing patients for the next three to four months. Shire is looking to the U.S. Food and Drug Administration and the Drug Enforcement Agency for help in obtaining additional sources of the drugs from other drug companies. The Somerville plant made amphetamine salts, which is a key ingredient in the two ADHD drugs. No cause of the explosion has been found. (*Reuters*)

... funding children's services.

Children NOW, the California Budget Project and other advocates for children and families in California are lobbying to receive some of the state's $4 billion surplus. The groups are particularly interested in using the money to create a state-earned income tax credit to lower taxes and therefore put more money back into the pockets of low-income working families. (*Children's Advocate*, July-August, 1998; For more information, contact Jean Tepperman, Action Alliance for Children, 1201 Martin Luther King Jr. Way, Oakland, CA 94612-1217; (510) 444-7136. E-mail: aac@4children.org.)

... weapons and aggression.

A recent study from the University of Missouri-Columbia indicates that merely identifying a picture of a certain type of weapon is enough to trigger aggressive thoughts. In two experiments, participants viewed a series of weapon and non-weapon stimuli in either picture or word form. Each was immediately followed by an aggression-related word such as "punch" or a non-aggression-related word such as "listen." They then were asked to read out loud as quickly as possible. Researchers found that exposure to a weapon picture or word increased aggressive thoughts and decreased the time needed to recognize and pronounce aggression-related words. (American Psychological Society, Washington, DC For more information, contact Elizabeth Ruksznis, APS, 1010 Vermont Avenue, NW, Suite 1100, Washington, DC 20005-4907; (202) 783-2077.)

What's New in Research

Frequency of health-risk behaviors surveyed

A new in-depth report from the Centers for Disease Control and Prevention in Atlanta on youth risk behavior conducted from February until May of 1997 looked at six categories of priority health-risk behaviors among youth. The report was part of the Youth Risk Behavior Surveillance System, which monitors youth risk behaviors among high school students from 33 states, three territories and 17 local surveys.

Seventy-three percent of all deaths among youth and young adults ages 10 to 24 resulted from four causes: motor vehicle crashes, other unintentional injuries, homicide and suicide. During the 30 days preceding the survey, 19.3 percent rarely or never wore a seat belt, 36.6 percent had ridden with a driver who had been drinking, 18.3 percent had carried a weapon, 50.8 percent had drunk alcohol and 26.2 percent had used marijuana. During the year prior to the survey, 7.7 percent had attempted suicide. Furthermore, 48.4 percent of high school students had sexual intercourse, 43.2 percent had not used a condom at last sexual intercourse and 2.1 percent had injected an illegal drug. Male students were more likely than female students to practice risky behavior.

The CDC recommends that the data be used to identify high-risk youth and target programs that are appropriate for them. Some states, such as Nevada, are using the data from the survey to create new health programs for youth. In San Diego, the data are used to encourage colleges and universities to become actively involved in re-

Recommended Reading: Expanded Section

A variety of books, of obvious interest to this newsletter's readers, have been received in the Editor's office. We take this opportunity to help you, our subscribers, catch up on your outside reading.

UNDERSTANDING CHILDREN'S DRAWINGS — *Cathy A. Malchiodi. New York: Guilford Press. 252 pages, $21.95 (paperback), 1998. (800)365-7006.*

OUR MOTHERS' SPIRITS: ON THE DEATH OF MOTHERS AND THE GRIEF OF MEN — *Bob Blauner. New York: Regan Books (HarperCollins). 315 pages, $23 (hardcover), 1997. (800)331-3761.*

TRUTH IN MEMORY — *S.J. Lynn & K.M. McConkey (Eds.). New York: Guilford Press. 508 pages, $50 (hardcover), 1998. (800)365-7006.*

DELINQUENT VIOLENT YOUTH: THEORY AND INTERVENTIONS — *T.P. Gullotta, G.R. Adams, & R. Montemayor (Eds.). Thousand Oaks, Calif.: Sage Publications. 320 pages, $29.50 (paperback), 1998. (805)499-0721.*

ANTISOCIAL BEHAVIOR BY YOUNG PEOPLE — *M. Rutter, H. Giller, & A. Hagell. New York: Cambridge University Press. 464 pages, $59.95 (hardcover), $18.95 (paperback), 1998. (212) 924-3900.*

CHILDREN IN A VIOLENT SOCIETY — *J. Osofsky. New York: Guilford Press. 338 pages, $18.95 (paperback), 1998. (800)365-7006.*

THE YOUNGEST MINDS: PARENTING AND GENES IN THE DEVELOPMENT OF INTELLECT AND EMOTION — *A.B. Barnet & R.J. Barnet. New York: Simon and Schuster. 352 pages, $26 (hardcover), 1998. (212)698-7360.*

CLINICAL DISORDERS AND STRESSFUL LIFE EVENTS — *T.W. Miller (Ed.). Madison, Conn.: International Universities Press. 41 pages, $62.50 (hardcover), 1997. (800)835-3487.*

PSYCHOLOGICAL DISTURBANCES IN YOUNG PEOPLE: CHALLENGES FOR PREVENTION — *Michael Rutter (Ed.). New York: Cambridge University Press. 403 pages, $44.95 (hardcover), $24.95 (paperback), 1997. (800)227-0247.*

PSYCHOLOGICAL ASSESSMENT OF CHILDREN: BEST PRACTICES FOR SCHOOL AND CLINICAL SETTINGS (2ND ED.) — *H. Booney Vance (Ed.). New York: John Wiley and Sons. 505 pages, $55 (hardcover), 1998. (800)225-5945.*

CONSEQUENCES OF GROWING UP POOR — *Greg. J. Duncan & Jeanne Brooks-Gunn (Eds.). New York: Russell Sage Foundation. 660 pages, $49.95 (hardcover), 1997. (800)666-2211.*

HANDBOOK OF AUTISM AND PERVASIVE DEVELOPMENTAL DISORDERS — *Donald J. Cohen & Fred R. Volkmar (Eds.). New York: John Wiley and Sons. 1092 pages, $95 (hardcover), 1997. (800)225-5945.*

COGNITIVE-BEHAVIOR THERAPY FOR PEOPLE WITH LEARNING DISABILITIES — *B.S. Kroese, D. Dagnan, & K. Loumidis (Eds.). New York: Routledge. 190 pages, $65 (hardcover), $19.95 (paperback), 1997. (800)634-7064.*

TEACHING PROBLEM STUDENTS — *Jere Brophy. New York: Guilford Press. 466 pages, $40 (hardcover), 1996. (800)365-7006.*

REWRITING FAMILY SCRIPTS — *John Byng-Hall. New York: Guilford Press. 288 pages, $18.95 (paperback), 1998. (800)365-7006.*

ADOLESCENT COPING: THEORETICAL AND RESEARCH PERSPECTIVES — *Erica Frydenberg (Foreword by Sanford M. Dornbusch). New York: Routledge. 233 pages, $69.95 (hardcover), $18.95 (paperback), 1997. (800)634-7064.*

MOTHERING AGAINST THE ODDS: DIVERSE VOICES OF CONTEMPORARY MOTHERS — *Cynthia Garcia Coll, J.L. Surrey, & K. Weingarten (Eds.). New York: Guilford Press. 288 pages, $38.95 (hardcover), $18.95 (paperback), 1998. (800)365-7006.*

OCD IN CHILDREN AND ADOLESCENTS: A COGNITIVE-BEHAVIORAL TREATMENT MANUAL — *J.S. March & K. Mulle. New York: Guilford Press. 298 pages, $32 (hardcover), 1998. (800)365-7006.*

NOT JUST A PASSING PHASE: SOCIAL WORK WITH GAY, LESBIAN AND BISEXUAL PEOPLE — *G.A. Appleby & Jeane W. Anastas. New York: Columbia University Press. 490 pages, $49.50 (hardcover), $21.50 (softcover), 1998. (800)944-8648.*

SEXUAL ADDICTION: AN INTEGRATED APPROACH — *Aviel Goodman. Madison, Conn.: International Universities Press. 464 pages, $65 (hardcover), 1998. (800)835-3487.*

TREATMENT OF CHILDHOOD DISORDERS (2ND ED.) — *E.J. Mash & R.A. Barkley (Eds.). New York: Guilford Press. 771 pages, $69.95 (hardcover), 1998. (800)365-7006.*

ADHD AND THE NATURE OF SELF-CONTROL — *R.A. Barkley. New York: Guilford Press. 410 pages, $40 (hardcover), 1997. (800)365-7006.*

DEVELOPMENTAL PERSPECTIVES ON TRAUMA: THEORY, RESEARCH, AND INTERVENTION — *D. Cicchetti & S.L. Toth (Eds.). Rochester, N.Y.: University of Rochester Press. 613 pages, $120. (hardcover), 1997. (716)273-5778.*

ASPERGER'S SYNDROMS: A GUIDE FOR PARENTS AND PROFESSIONALS — *Tony Attwood. Philadelphia: Jessica Kingsley Publishers. 224 pages, $18.95 (paperback), 1998. Available from Taylor & Francis, (800) 821-8312.*

WORKING WITH CHILDREN OF ALCOHOLICS: THE PRACTITIONER'S HANDBOOK (2ND ED.) — *B.E. Robinson and J.L. Rhoden. Thousand Oaks, Calif.: Sage Publications. 233 pages, $23.50 (paperback), 1998. (805)499-0721.*

ATTENTION-DEFICIT HYPERACTIVITY DISORDER: A HANDBOOK FOR DIAGNOSIS AND TREATMENT (2ND ED.) — *R.A. Barkley. New York: Guilford Press. 628 pages, $55 (hardcover), 1998. (800)365-7006.*

Accompanying workbook:

ATTENTION-DEFICIT HYPERACTIVITY DISORDER: A CLINICAL WORKBOOK — *R.A. Barkley & K.R. Murphy. New York: Guilford Press. 133 pages, $28.95 (paperback), 1998. (800)365-7006.*

BECOMING ANNA: THE AUTOBIOGRAPHY OF A SIXTEEN-YEAR-OLD — *Anna J. Michener. Chicago: The University of Chicago Press. 256 pages, $22. (hardcover, 1998). (800)621-2736.*

THE ESSENTIAL GUIDE TO GROUP PRACTICE IN MENTAL HEALTH: CLINICAL, LEGAL, AND FINANCIAL FUNDAMENTALS — *S.H. Budman & Brett N. Steenbarger. New York: Guilford Press. 318 pages, $45 (hardcover), 1997. (800)365-7006.*

SPLITTING UP: ENMESHMENT AND ESTRANGEMENT IN THE PROCESS OF DIVORCING — *Alvin Pam & Judith Pearson. New York: Guilford Press. 448 pages, $40 (hardcover), 1998. (800)365-7006.*

IMPULSIVITY: THEORY, ASSESSMENT, AND TREATMENT — *C.D. Webster & M.A. Jackson (Eds.). New York: Guilford Press. 450 pages, $45 (hardcover), 1997. (800)365-7006.*

LOST CHILDHOODS: THE PLIGHT OF THE PARENTIFIED CHILD — *G.J. Jurkovic. New York: Brunner/Mazel (Taylor & Francis Group). 282 pages, $34.95 (hardcover), 1997. (800)821-8312.*

COCAINE-EXPOSED INFANTS: SOCIAL, LEGAL, AND PUBLIC HEALTH ISSUES — *J.A. Inciardi, H.L. Surratt, & C.A. Saum. Thousand Oaks, Calif.: Sage Publications. 116 pages, $18.95 (paperback), 1997. (805)499-0721.*

SPOILING CHILDHOOD: HOW WELL-MEANING PARENTS ARE GIVING TOO MUCH — BUT NOT WHAT THEY NEED — *Diane Ehrensaft. New York: Guilford Press. 263 pages, $18.95 (hardcover) 1997. (800)365-7006.*

Surviving the holidays

Less stress for you and more fun for the whole family

You remember the holiday dinners of your childhood. Your mother spent days making cookies, baking apple and pumpkin pies, and chopping vegetables. All 15 of the relatives came over on the big day and expected to sit down for an elaborate meal. And you didn't see your mother all day — she was in the kitchen.

Things are different now. You go to work outside the home every day. You have to take children to school, drop off and pick up from daycare, take them to soccer practice and make dinner. And that's on an average day. The holidays provide an entirely different set of challenges.

Linda Goodman Pillsbury, author of *Survival Tips for Working Moms*, has come up with a five-step strategy to help you get through the holidays with a minimum of stress. Pillsbury says you have to realize you can't do everything your mother did and you shouldn't expect to. Lose the guilt. The point of the holidays is to have fun, not to prove to everyone "you can put on the best show." A frantic and over-worked mother is a mother who's not having a good time. You want your children to grow up with fond memories of their holidays. And to make sure that happens, you have to make it a stress-free and fun day for everyone — including yourself.

1. Sit down and make a list of all the things you'd like to have or do to help make your holiday special: Cooking, entertaining guests, dressing up, traditional stories, songs, etc. Ask yourself which family member has the responsibility for each of the items on your list. If the answer for almost all the items is "you" (and it probably is), then you're doing too much. It's time to cut down and to redistribute some of the responsibility. What is it that makes the holiday special for you? Perhaps you place importance on a big Thanksgiving dinner, or maybe it's beautiful home decorations that you care about. Whatever it is, Pillsbury says, make sure it's what you value, not what you think "your mother will grade you on."

2. Look at your list and pick out one or two items. You know it's impossible to do it all, so choose only those things that are the *most* important to you. Then plan ahead. If you like to bake, and having an assortment of homemade pies for dessert means a lot to you, plan a time when you can make them. As for the rest of the meal, perhaps friends or family members can help prepare it. If decorating is important, spend your time on making your home look spectacular and turn dinner into a potluck. Make sure you put your time and effort into what you enjoy and make everything else as easy as possible for yourself.

3. Keep it simple. If having a large dinner party for 25 people is important to you, no matter how much you enjoy entertaining, you know that's not a simple project. You have to *make* it simple. Have a potluck dinner instead of preparing the entire meal yourself. If you think that your elderly relatives won't approve of a potluck holiday dinner, order premade dishes from a local restaurant or grocery store. Your relatives never need to know! Buy juice instead of mixing your own punch. If you remember 10 different varieties of cookies from your childhood holidays, don't feel you have to do the same thing. Pick the two or three cookies your family likes the best and make those. Prepare the cookie dough one day, and schedule another day for the baking. The point is to make it

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easy and fun. Keep your menu simple — just because your Aunt Linda served an elaborate Thanksgiving dinner doesn't mean you have to. Nobody will mind if you don't give them three different sweet potato dishes.

4. Involve your children. According to Pillsbury, many woman feel that they miss out on the holiday entirely, spending their day stuck in the kitchen. By involving your children, you give them more ownership of the holiday. What they'll remember about the holiday is their participation in it. If you're making cookies, you can have your children help you roll out the dough or decorate the cookies. This makes it a fun project for the whole family as well as ensuring that you're not just "the slave in the kitchen." Keeping things simple also has another advantage: Simple tasks are ones your children can help with as well. If you buy prepackaged salad, pouring it into a salad bowl is a job any child can help with. Paper plates not only make things easier for you, but also make it possible for young children to help without the risk of breaking china. Remember: Don't get hung up on perfectionism.

5. Have fun on the holiday itself. This sounds obvious, but it's something that many working mothers overlook. If you've planned ahead and done all the grocery shopping and preparations you intend to do, sit back and relax. Don't spend the day in the kitchen. Make sure you have time to have fun. Pillsbury says that often it is mothers who make the holiday, but fathers who are the ones the children associate with the holiday. While Mom is in the kitchen basting the turkey, Dad is playing soccer outside with the children. Pillsbury says you should make sure you get to "join in those Kodak moments!"

Once you've followed Pillsbury's steps, you should be free to enjoy your holidays with your children. It won't matter that you're not continuing your mother's tradition of a perfect holiday dinner. Perfectionism isn't all it's cracked up to be. Freeing yourself from some of the holiday trappings will allow you to start some of your own traditions — some low-maintenance and *easy* traditions. Try incorporating the meaning of the holiday into your festivities. Read a holiday story after dinner. Sing holiday songs in the evening. Whatever you do, don't create more work for yourself. You can make the holidays fun for your whole family and ensure that your children's holiday memories are happy ones.

For more information, contact Linda Goodman Pillsbury at Perspective Publishing at (818) 502-1270.

The Brown University **Child and Adolescent Behavior Letter**

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ducing alcohol use among teenagers.

Kann L, Kinchen SA, Williams BI, et al. Youth Risk Behavior Surveillance — United States, 1997. *Morbidity and Mortality Weekly Report* 1998; 47(SS-3):1-92. For reprints, contact Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402; (202) 512-1800.

Guidelines outline weight-management goals

The U.S. Department of Health and Human Services' Maternal and Child Health Bureau has released guidelines for practitioners for the evaluation and treatment of overweight children and adolescents. Children with a body mass index (BMI) greater than or equal to the 85th percentile with complications of obesity or with a BMI greater than or equal to the 95th percentile should undergo evaluation and possible treatment. The guidelines warn clinicians to be aware of possible causes of obesity such as endocrine disorders, and to screen for complications such as hypertension and insulin resistance.

Because of the shame and embarrassment many overweight children feel about their size, the recommendations strongly encourage clinicians to treat overweight children with sensitivity and compassion, and to approach obesity as a medical problem that can be treated. For example, the clinician should ask overweight children if they sometimes feel their eating is out of control instead of asking them if they lack willpower.

These are the key components to a successful weight-management program for overweight youth and their families:

- The development of awareness of current eating habits, activity levels and parenting behavior.
- Identification of problem behaviors, such as helping children identify specific high-calorie foods or eating patterns and obstacles to physical activity.
- Modification of current behavior by making a few small, permanent changes at a time and making additional changes only after the previous changes are firmly in place.
- Continued awareness of behavior and recognition of problems that arise as the child becomes more independent, as family schedules change or as other changes occur that alter the initial treatment plan.

In addition, the guidelines emphasize the importance of ensuring that parents praise the child's behavior, not use food as a reward, establish daily family meal and snack times, offer healthy options and become a good role model themselves to their children.

Barlow SE, Dietz WH: Obesity evaluation and treatment: Expert committee recommendations. *Pediatrics* 1998; 102:1-21. For reprints, contact the National Maternal and Childhealth Clearinghouse, 2070 Chain Bridge Road, Suite 450, Vienna, VA 22182-2536. E-mail: nmchc@circsol.com.

Substance abuse
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ers are likely to say, "Why not?"

Parents fail to challenge teen thinking

Seeing no reason not to binge drink at parties and before school events suggests that well-to-do teenagers have not been challenged to think about what is healthy and responsible. Research indicates that assumption is correct. And not talking about responsible health behavior is made worse when parents believe that teenage drinking is okay, even expected. Conversely, when parents set clear rules about drinking, talk with their teenagers about their concerns, and monitor friends and activities, the most dangerous patterns of drinking are prevented.

Of course, to be effective, parents cannot wait to begin these discussions until the teen years. Moreover, any discussion will be worthless if accusations and recriminations abound. In that context, teenagers are like the rest of us. Angry exchanges just make them shut out their accuser. A wise parent will take advantage of family rituals to build good will and affection with their teenagers, support their development and set aside the time to talk about their drug use concerns. Parents whose focus is inordinately on work and making money, and who are too busy to spend quality time with their child and come to know their child's friends and their after-school routines, will likely regret their priority decisions come high-school.

Drug use by teenagers who grow up in impoverished homes, however, has different roots. It's generally agreed that poor family management practices, transient living, chaotic neighborhoods and low value for academic achievement, among other factors, contribute to drug abuse. While it's wrong to assume that these conditions prevail for all poor children, it's true that these factors are common for impoverished youth,

especially those being raised by a single parent.

Mistaken beliefs about users

Identifying the factors that contribute to drug use neither explains how those factors work, nor why they exist. And, just as people tend to think mistakenly that drug use is a manifestation of mental illness, some people believe that poor peoples' circumstances are largely of their own making.

The view that poor people have created their own impoverishment is not supported by the facts. Many poor people work as much as they are able but not as much as they want (many employers now hire two part-time people to do the job of one full-time worker). Poor people often make minimum wage working for companies that pay record dividends to stockholders. Taken together, these conditions will significantly increase the risk of drug use for children of lower income families.

Under the trying conditions associated with poverty, poor parents are less able to practice effective family management strategies. Those parents, working on holidays and weekends, are typically less able to monitor their children's activities and probably don't know their children's friends and their drug use habits. Also, those parents are not likely to keep tabs on their children's school performance nor are they likely to easily promote academic achievement. Declining academic achievement in the middle school years is strongly associated with the adoption of a drug abuse lifestyle.

Addressing the factors that contribute to drug use by poor children will require that we as a people address the policies and social conditions that have enlarged the gap between the "haves" and the "have nots." In the context of drug use, we have to understand that these economic facts mean that in most poor families both parents work, leaving them little time to socialize and monitor their children's development. Also, economic-related stress and the loss of self-worth that occurs when people can no longer adequately care for their family have devastating effects on children who can be expected to have low self-worth, achievement motivation and expectations for a good life. When life holds so little promise, it's not surprising that young people, supported by their equally uninspired peers, turn to drugs and engage in other problem behaviors.

Nothing in this analysis points to the problem of drug use being caused by mental problems. And while this analysis identifies only some of the known factors associated with teenage drug use, it does identify precipitators that society could address if people had the understanding and will to do so. Affluent parents can come to understand that their exaggerated materialism has consequences that are antithetical to their children's social development. And legislators and economists can come to understand that many of this nation's poor need the same advantages in the workplace (full and fair employment and compensation) that are available to the empowered. Likewise, those poor people need the other advantage that helps so many of the wealthy — a tax code that leaves more of their hard earned money in their pockets. If legislators paid as much attention to using the negative income tax for the poor as they do cutting capital gains taxes for the very wealthy, all of us, especially, youngsters who are at risk for drug abuse, would be better off. The choice is ours to make. ■

John J. Colby is project director of the Center for Substance Abuse Prevention Community Partnership Grant and a professor of psychology at Providence College, in Rhode Island.

Preventing substance abuse starts with family

The Center for Substance Abuse Prevention, a division of the Substance Abuse and Mental Health Services Administration (SAMHSA) in Washington, D.C., has published a guide titled, "Preventing Substance Abuse Among Children and Adolescents: Family-Centered Approaches." The guide teaches that family involvement is the key to preventing substance abuse in children and adolescents, and contains information on parent and family skills training to improve poor parent-child communication, on in-home support services and on family therapy.

The guide comes in three forms: A community guide in the form of a brochure overview, a practitioner's guide in the form of a brief guide for practitioners, and a resource guide, a book length publication for communities and families. To receive a free copy of the guides, contact the National Clearinghouse for Alcohol and Drug Information at P.O. Box 2345, Rockville, MD 20847-2345; (800) 729-6686. E-mail: www.health.org.

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showed tobacco use and another study revealed that four out of five of the male leads in the top-grossing films lit up.

"The silver screen has become a smokescreen, with tobacco users frequently portrayed as powerful, in control, exciting and rebellious — an image that mirrors tobacco industry advertising," said James Allen, M.D., M.P.H., director of ADHS. "This celluloid image is particularly dangerous because of the enormous impact of popular culture on our children."

A study conducted by the University of California-Irvine found that ninth graders who viewed an anti-smoking ad before watching a movie in which the main characters smoke were more likely to resist the positive images of smoking.

On-screen advertising offers other advantages as well, including wide coverage at a low cost, high recall and a captive and definable audience.

Recall is high, cost is low

According to attendance estimates provided by the theaters, the cinema spots are being seen by about 700,000 customers per week. The spots typically will run from one to three months, depending on the theater. Since volume advertising rates were obtained, the weekly per-screen cost did not surpass $74 at any theater, and frequently the tab was much lower. One theater, The Towne Square in St. Johns, is running the spots for free. Total cost is $156,046, all financed by the tobacco tax increase approved by voters in 1994.

Recall for on-screen advertising purportedly is three times that of any other medium. The Association of Theater Screen Advertising found that audiences recalled cinema spots at a rate of more than 65 percent after four weeks.

The trend toward more tobacco in movies began early this decade, when, according to industry insiders, Hollywood turned away from political correctness. Researchers at the University of California at San Francisco analyzed the five top-grossing films each year and found that while only one lead character smoked in 1990, 80 percent of the male leads smoked in 1991-96. A 1993 study by cardiologists at the same university found that movie screens featured double the number of young smokers from 30 years ago.

An American Lung Association study of 133 movies released in 1994-95 found that 77 percent of the films showed tobacco use and 53 percent showed cigar smoking. A USA Today survey of 18 movies, conducted in 1996, found that the top 10 revenue-grossing movies all featured tobacco use and that only one of the movies included in the survey — "D3: The Mighty Ducks" — did not involve tobacco.

Earlier this year "Titanic," the top grossing movie of all time, was designated for an "Hackademy Award" by the American Lung Association. The film's young stars — Leonardo DiCaprio and Kate Winslet — both smoke in the film and Winslet lights up at the dinner table in an act of cool defiance. In "My Best Friend's Wedding," another movie extremely popular with pre-teen and teenage girls, Julia Roberts puffs away. In "Men in Black" there is the suggestion that Marlboro cigarettes are the only thing worth saving on the planet.

In a study published earlier this year, seven in 10 Californians surveyed said they believed smoking by actors and actresses in movies and TV influences minors to start smoking. And, by nearly a two to one margin, participants said they believed the media has had a negative, rather than a positive, effect on youths' attitudes about smoking.

The ADHS tobacco prevention program was launched in early 1996. Other elements of the tobacco-tax-funded campaign include community- and school-based activities; radio, television and billboard advertising; a touring walk-through exhibit called the Ash Kicker; tobacco-prevention clothing and merchandise; and a tobacco-cessation hotline (800) 556-6222. ■

Brad Christensen is editor of the Arizona Department of Health Services newsletter, *HealthLink*. A version of this article appeared in the June-August issue of that publication. For more information about their programs, contact the ADHS Public Information Office, 1740 W. Adams, Room 407, Phoenix, AZ 85007. Phone (602) 542-1001.

Statement of Ownership, Management and Circulation

The Brown University Child & Adolescent Behavior Letter is published monthly for $177 a year for institutions and $117 a year for individuals by Manisses Communications Group, Inc., 208 Governor Street, Providence, RI 02906-0757. It is owned by a group of class A, B, or C preferred and common stockholders whose names are on file with the U.S. Postal Service and are available upon request. Publisher: Fraser A. Lang; Editor: Lewis P. Lipsitt; Senior Managing Editor: Linda Watts Jackim. ***The Brown University Child & Adolescent Behavior Letter*** has an average monthly circulation of 3,749. The average number of copies per issue printed during the past year is 4,280: 431 complimentary subscriptions and 100 for office use. The circulation of the single issue published nearest to filing date was 1,957. The actual number of copies of the single issue printed nearest to filing date was 2,419: 362 complimentary subscriptions and 100 for office use.

Guest Commentary

Adolescent criminals: Where do they come from, where do they go?

By Thomas J. Cottle, Ph.D.

When watching television news on any given day, we might see a gruesome account of a man who has just killed his wife and then turned the gun on himself, while his four-year-old son watches. "My God," we say with great compassion. "What must that child be thinking? How can he live through something like this? Whatever will become of that poor child?"

Now, fast-forward about 12 years. Picture that boy, now 16 years old, standing in a courtroom with that characteristic posture that veritably screams, "I could care less about anything!" Now we don't view him with compassion or think of him as a traumatized patient. Rather we see him as a prime example of a psychopath, macho thug, heartless animal or the embodiment of evil. "My God," we say with outrage, "Sixteen years old and already a list of offenses as long as his arm! What's wrong with him?"

If a child is immoral, then so too are the conditions that spawn that immorality. The whole notion of a child at risk rests in great measure on the notion of immorality in the society.

It's sobering to realize that quite possibly the most dangerous person in America is the 16 year old boy drifting about after school with no place to go and access to a gun. He is not yet old enough to drink (legally) or join the army, but he is old enough to drive, drop out of school, and most definitely to kill if he has the opportunity, the inclination and the desire.

Obviously, we must do something about criminal offenders, be they young or old. They represent a risk to us personally, as well as to the desired civil order. However, the debate on exactly what to do has never reached a conclusion. All it takes for this debate to escalate is the sort of grizzly schoolyard murders we witnessed this year in Massachusetts, Kentucky and Arkansas. At times such as these, our outrage toward youthful offenders causes us to reconsider the juvenile justice system, the methods of adjudication and the punishments that ought to be meted out in cases of serious crime.

The debate swings between those who argue that crime is crime whether it be committed by a 13-year-old or a 40-year-old, and those who believe that something horrendous must have gone wrong for a child who commits a murder or rape. Surely, they argue, this child is immature, underdeveloped, neglected or abused, but not evil. Quite possibly, they argue, because he is young, he may be rehabilitated. Besides, they ask, what is prison going to do for the child other than permanently galvanize his furious impulses and turn the still malleable youngster into a hardened life long criminal?

What a society elects to do with its young offenders depends on how that society chooses to perceive them. Tragically, crime is one of the ways that traumatized children react to earlier wounds. It will take a great deal of work to get them in touch with their pain, humiliation and sense of shame that stems from their perception — not that they have *done* bad — that they know themselves to *be* bad.

Something must be done, not *to*, but *for* all these children at risk. If a child is immoral, then so too are the conditions that spawn that immorality. The whole notion of a child at risk rests in great measure on the notion of immorality in the society. When it's a matter of a child in trouble here or there, or every now and then, we just take another philosophical position. But generation after generation of offenders tells us that pathology and immorality must breed this condition.

Trauma rarely shows. We see only its ugly, frightening repercussions. ■

Thomas J. Cottle is a sociologist and practicing clinical psychologist, and professor of Special Education at Boston University. He is the author of the forthcoming *Hardest Times*, a study of long term unemployed men (W.W. Norton & Company Inc. (800) 233-4830). Contact Cottle at (617) 566-6426.

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ISSN 0898-2562

The Brown University Child and Adolescent Behavior Letter

Monthly reports on the problems of children and adolescents growing up.

Social Skills

In a season of overindulgence, gratitude doesn't have to be a lost emotion

By Susan R. Pollack

Beverly Moseley didn't know what to make of her grandson when she asked him what he wanted for his seventh birthday.

Accustomed to hearing children rattle off a wish list of expensive toys, Moseley, a Detroit teacher, was surprised at Jon Morgan's modest response: " 'Whatever you give me is fine, Grandma,' " he said.

But as many parents know all too well, that's not a typical answer.

Most children have very specific wants that they express in no uncertain terms. And when at holiday time they open a box containing a boring sweater instead of the hot new video game they desired, they'll toss it aside with disinterest or, at best, a mumbled thank you, leaving their parents squirming with embarrassment. How can such uncomfortable moments be avoided?

> ***"Ultimately, children are likely to learn to show gratitude naturally if they observe similar behavior played out within the family."***
>
> ***— Julius Segal***

First, the good news is that behavioral psychologists say all children are born with feelings of gratitude in varying degrees.

Deborah Morgan of Detroit, Jon's mother, says she started early to nurture these feelings. She began

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Inside This Issue

Each year more than 80,000 children require special education as a result of prenatal cocaine exposure.
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Methylphenidate's slow absorption rate makes it unlikely to cause a "high" in users.
See page 3

Commentary: The human technology of parenting.
See page 8

This month's client handout:
Toy tips for the holidays

Adolescent Suicide

Teenagers commonly question the why and how of suicide

by Brian Barr, C.S.W., C.A.S.A.C.

As a mental health practitioner, I have worked with teenagers for more than 30 years. For the past 14 years, since my family and I lost our 18-year-old son, Kevin, to suicide, I have been talking to teenagers about suicide, and more importantly, listening to their questions on the subject. Three questions come up repeatedly: WHY would someone want to kill himself or herself? WHAT can you do when you know a person who is suicidal and who won't let you help? And, HOW do people commit suicide?

Statistics show that since 1955, the teen suicide rate has risen nearly 400 percent. Between 1957 and 1987, the number of completed suicides rose 312 percent for youth between the ages of 15 and 19. And suicide deaths for children under age 15 are rising dramatically. Estimates indicate more than half of high-school students have thought about suicide.

In my years of addressing the subject, I've learned that the stigma surrounding suicide is so great that some teens hesitate to

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Editor: Lewis P. Lipsitt, Ph.D.
Professor Emeritus of Psychology, Medical Science, and Human Development at Brown University

Contributing Editors:

Stephen L. Buka, Sc.D., Associate Professor, Department of Maternal and Child Health, Harvard University School of Public Health

Cynthia Garcia Coll, Ph.D., Professor, Education, Psychology and Pediatrics, Chair of Education Department, Brown University

Ferdinand Jones, Ph.D., Professor of Psychology, Brown University, formerly director of Brown University Student Counseling

Dwight B. Heath, Ph.D., Professor Ementus of Anthropology, Brown University

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Carol Lewis, M.D., Clinical Instructor in Pediatrics, Brown University School of Medicine, private practice

Theodore R. Sizer, Ph.D., University Professor Emeritus, Brown University; Chairman, Coalition of Essential Schools, former director, Annenberg Institute for School Reform

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The Brown University Child and Adolescent Behavior Letter (ISSN 0898-2562) is published monthly by Manisses Communications Group, Inc., 208 Governor St., Providence, RI 02906; (401) 831-6020; fax: (401) 861-6370; e-mail: lwjackim@manisses.com. Yearly subscription rates are $177 for institutions and $117 for individuals. Periodicals postage at Providence, RI. POSTMASTER: Send address changes to: Manisses Communications Group, Inc., P.O. Box 9758, Providence, RI 02940-9758. ©1998 by Manisses Communications Group, Inc. Member, Newsletter Publishers Association. **The Brown University Child and Adolescent Behavior Letter** reports monthly on work in child development. Our purpose is to provide timely, accurate information by drawing on professional journals, expert opinion and the experience of our editors and guest writers. **The Brown University Child and Adolescent Behavior Letter** does not offer medical, legal or administrative services and we encourage subscribers to seek advice from qualified professionals. **The Brown University Child and Adolescent Behavior Letter** is available in reference systems produced by Information Access Company. For more information, contact Information Access Company, Rights & Permissions Dept., 362 Lakeside Drive, Foster City, CA 94404, or call (800) 227-8431 (U.S. only) or (415) 378-5000. All rights reserved. Reproduction forbidden without the consent of the publisher. Authorization to photocopy articles for internal or personal use or the internal or personal use of specific clients, is granted by Manisses Communications Group provided that the fee of $6.00 per article is paid to the Copyright Clearance Center, 222 Rosewood Drive, Danvers, MA 01923, (508) 750-8400.

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Printed in USA

Keep Your Eye On

... prenatal cocaine exposure.

Prenatal cocaine exposure lowers IQ and language performance scores in school-age children, according to a new study from Brown University in Providence, R.I. In fact, such exposure is linked to 80,550 children requiring special education services each year at a cost of up to $352 million, says Barry M. Lester, Ph.D., professor of psychiatry and human behavior at the university and lead author of the study. The study is the first research that has evaluated the long-term effects of prenatal cocaine exposure in school-age children.

The study assessed 800 school-age children from eight studies. Using meta-analysis, a statistical method for pooling studies to gather data, Lester and colleagues determined the estimate of the effect of prenatal cocaine exposure. They measured IQ, receptive language and expressive language. On average, children who had been exposed to cocaine prenatally had IQ scores that were 3.26 points lower than children who were not exposed. With language tests, twice as many children who were exposed to cocaine prenatally had difficulty.

However, Lester adds that sorting out the effects of prenatal cocaine exposure from the effects of other risk factors that may lower IQ scores, such as poverty, is complicated. In addition, he says the drop of only slightly more than 3 IQ points in the exposure children indicates that damage from prenatal cocaine use is not as severe as was once anticipated.

"I don't want the pendulum to swing to the other side," Lester explains. "We started out with hysteria about cocaine devastation, and it would be dangerous for the pendulum to swing to the other side and say the effects aren't there or they are all environmental."

For more information on the study, which appeared in the October 23, 1998 issue of *Science*, contact Kristen Lans, Brown University News Bureau, 38 Brown Street, Box R, Providence, RI. 02912; or e-mail kristen_lans@brown.edu.

... teens and religion.

High school seniors who attend church are less likely to drink and drive and practice other unhealthy behaviors, according to a study from the University of Michigan in Ann Arbor. John M. Wallace, Jr., Ph.D., and colleagues analyzed survey responses from 5,000 high school seniors from around the nation. The teens were asked about their religious participation and beliefs as well as behaviors that could affect their health.

At least one-third of the teens said they attended religious services once a week and that religion was "very important" to them. Those teens were less likely to drink and drive, carry a weapon, use tobacco or marijuana, or get into fights. They also were more likely to wear seat belts, eat healthy foods and get enough sleep.

Wallace notes that religion not only helps "constrain behavior, but it also encourages or promotes adolescents' involvement

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in behavior that can protect or enhance their health."

For more information, contact John M. Wallace, Jr., Ph.D., University of Michigan School of Public Health, Department of Health Behavior and Health Education, 1520 Washington Heights, Ann Arbor, MI 48109-2029; or e-mail johnwall@umich.edu.

... methylphenidate abuse.

There is low potential for abuse or addiction with methylphenidate (Ritalin), the stimulant drug used to treat attention-deficit/hyperactivity disorder (ADHD). The study, from the October 1, 1998 issue of the *American Journal of Psychiatry*, confirms that oral doses of methylphenidate do not reach peak concentrations in the brain until 60 minutes after ingestion compared to five minutes for cocaine. Because methylphenidate is absorbed so slowly by the brain, it is unlikely to cause a "high" in users.

Alan I. Leshner, Ph.D., director of the National Institute on Drug Abuse (NIDA) in Bethesda, Md., which helped fund the study, says the research helps clarify why methylphenidate "rarely leads to abuse and addiction when taken properly as a treatment for ADHD."

The study also helps explain why people who don't have the disorder could abuse methylphenidate or become addicted to it, especially when it is taken intravenously or crushed and inhaled. Intravenous use or inhaling the crushed pills would make the drug enter the brain quicker, he adds.

"It is extremely important to clarify that different methods of taking a medication can alter its medicinal effects and make it more or less dangerous in ways totally unrelated to its clinical indications."

Resources

Video helps teens say no to destructive relationships

Sunburst Communications in Pleasantville, N.Y., has developed a video for middle-schoolers, "When Friends Meet Trouble," to help them recognize and deal with inappropriate behavior from their peers. The 19-minute program, which includes a teacher's guide with discussion questions and role-playing ideas and six real-life vignettes. In one situation, a boy is convinced by a friend to steal a stop sign; he then gets into trouble with police. Another scenario depicts a girl belittling a classmate, even though she claims to be her friend.

The discussion portion of the program includes helping students evaluate their friendships, as follows:

- To be able to identify the qualities to look for in a friend.
- To distinguish between positive and negative peer pressure.
- To better understand their right to maintain their values in the face of peer pressure.
- To develop assertiveness strategies to use when there is trouble with friends.

The video and teacher's guide are available for $99.95 from Sunburst Communications, 101 Castleton Street, P.O. Box 100, Pleasantville, NY 10570; phone (800) 431-1934; fax (914) 747-4109.

For more information on the study, contact Nora D. Volkow, M.D., Medical Department, Brookhaven National Laboratory, Upton, NY 11973; or e-mail volkow@bnl.gov.

... teen marijuana use.

A federal study from the Substance Abuse and Mental Health Services Administration (SAMHSA) indicates there is a wide range of behavioral problems associated with marijuana use by teens, including suicidal thoughts and stealing.

Among a study of adolescents ages 12 to 17, those who used marijuana weekly were found to be nine times more likely than nonusers to experiment with illegal drugs or alcohol. The marijuana users were six times more likely to run away from home, five times more likely to steal, almost four times more likely to engage in violence, and three times more likely to have thoughts about committing suicide.

To obtain a free copy of the report, contact SAMHSA's National Clearinghouse for Alcohol and Drug Information at (800) 729-6686; or e-mail www.samhsa.gov.

... orphanages instead of foster care.

A prominent psychiatrist is in support of placing more foster children in orphanages because they may offer a better alternative than a "dysfunctional home" with a biological family or "unstable" foster care. Jerry M. Wiener, M.D., a psychiatrist at George Washington University in Washington, D.C., says the current sys-

tem of foster care is "beleaguered," and that, too often, children are sent back to biological families that are "abusive" or "inadequate."

Wiener says orphanages went out of favor after World War II because they were considered too institutional and impersonal, but that was not always the case. In addition, the current foster care system is "overwhelmed" with a high incidence of illegitimate births to teenage mothers, by increases in spousal abuse, and other negative factors. Orphanages should be considered "as one option available, when whatever the reason, neither adoption nor return to the family is possible," says Wiener.

For more information, contact Jerry M. Wiener, M.D., Department of Psychiatry, George Washington School of Medicine, 2150 Pennsylvania Ave., NW, Washington, D.C. 20037.

What's New in Research

Passive smoking linked to low birth weight

Pregnant women should be strongly encouraged to avoid spending time in places where people smoke, say the authors of recent research. A one-year cohort study of women exposed to passive smoking at home or at work was conducted in Malmo, Sweden. During their first prenatal visit, women completed a questionnaire about exposure to passive smoking. Among 826 women who had single live births, 6.7 percent of the infants were small for their gestational age.

Passive smoking in early pregnancy was found to double the women's risk of delivering a small-for-gestational-age infant independent of potential confounding factors such as age, height, weight, nationality and educational level.

"Based on an attributable risk estimate, a considerable reduction in the incidence of small-for-gestational-age births could be reached if pregnant women were not exposed to passive smoking," the authors conclude.

Dejin-Karlsson E, Hanson BS, Ostergren PO, et al.: Does passive smoking in early pregnancy increase the risk of small-for-gestational-age infants? *American Journal of Public Health* 1998; 88:1523-1527.

Skateboarding more risky than in-line skating

In a cross-sectional comparison of 154 roller skaters, 190 in-line skaters and 254 skateboarders ages five to 19 years who were hospitalized with injuries, investigators found that skateboarders had far more injuries than the other two groups.

The data were obtained from 79 hospitals and pediatric trauma centers participating in the National Pediatric Trauma Registry between October 1988 and April 1997. More than three-fourths (75.8 percent) of the study participants were male, and almost half (47.8 percent) were injured on roads. In addition, more than half (50.8 percent) of skateboard participants had head injuries compared to 33.7 percent of in-line skaters and 18.8 percent of roller skaters.

Using the Injury Severity Score, injuries to skateboarders were eight times more likely to be severe or critical compared to roller skaters' injuries and more than two times as likely to be severe or critical compared to in-line skaters' injuries.

The mean hospital length of stay was 6 days for skateboarders compared to 3.4 days for in-line skaters and 2.4 days for roller skaters.

"Skateboarding-related injuries are more severe and have more se-

Recommended Reading

LEGAL ISSUES IN CHILD ABUSE AND NEGLECT PRACTICE (2ND ED.) DANGEROUS RELATIONSHIPS: PORNOGRAPHY, MISOGYNY, AND RAPE — *John E.B. Myers. Thousand Oaks, Calif.: Sage Publications. 411 pages, $24.50 (softcover), 1998. (805) 499-0721.*

SPECIFIC READING DISABILITY: A VIEW OF THE SPECTRUM — *B.K. Shapiro, P.J. Accardo and A.J. Capute, Eds. Timonium, Md.: York Press. 267 pages, $33.50 (softcover), 1998. (410) 560-1557.*

THE ABCS OF LEARNING DISABILITIES — *Bernice Y.L. Wong. San Diego, Calif.: Academic Press. 266 pages, $39.95 (hardcover), 1996. (800) 321-0926.*

LEARNING ABOUT LEARNING DISABILITIES (2ND ED.) — *Bernice Y.L. Wong. San Diego, Calif.: Academic Press. 754 pages, $59.95 (hardcover), 1998. (800) 321-0926.*

Toy Tips For the Holidays

The Matching Game

- ✓ Toys should be matched to a child's abilities. The manufacturer recommendations serve as a useful guide.
- ✓ A toy that is too advanced or too simple for a child may be misused, which can lead to injury.
- ✓ Think BIG when choosing toys. All toy parts should be larger than the child's mouth to prevent injuries, including choking.

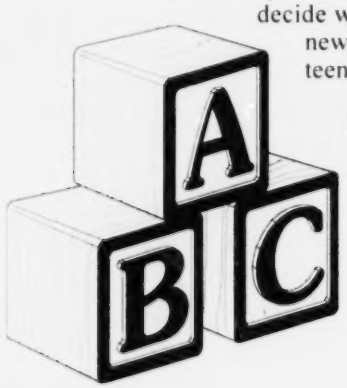
Purchasing Tips

- ✓ Before buying a toy, read the instructions. If the toy is appropriate for the child, read the instructions to the child for proper use of the toy.
- ✓ To avoid risk of serious eye or ear injury, avoid toys that shoot small objects into the air, or make loud or shrill noises. Parents can hold the noise-making toy next to their ear to determine whether it will be too loud for a child's ears.
- ✓ Look for sturdy toy construction. The eyes, nose, and other small parts on soft toys and stuffed animals should be securely fastened on the toy. In addition, avoid toys with sharp edges.

For the Older Crowd

- ✓ Never buy hobby kits, such as chemistry sets, for any child younger than 12 years old. Provide proper supervision for children 12 to 15 years of age.
- ✓ Tips of arrows or darts should be blunt, made of soft rubber or flexible plastic and securely fastened to the shaft.

A child's pediatrician can help parents decide which toys are safe for newborns, toddlers, and teens.



For a brochure on toy safety, which includes a list of age-appropriate toys for newborns to 14-year-olds, go to the American Academy of Pediatrics (AAP) Web site at www.aap.org, and click on "You and Your Family," then "AAP Public Education Brochures," then "Toy Safety."

Age-appropriate Toys

The following is a list of toys that the AAP recommends for specific age groups. Use these recommendations when shopping for toys. However, always remember that these are merely guidelines. Parents should continue to watch out for mislabeled toys and always provide proper supervision for younger children.

Newborn to One-Year-Old Baby

Choose "eye-catching" toys that appeal to your baby's sight, hearing, and touch.

- Large blocks of wood or plastic
- Pots and pans
- Rattles
- Soft, washable animals, dolls or balls
- Bright, movable objects that are out of baby's reach
- Busy boards
- Floating bath toys
- Squeeze toys

One- to Two-Year-Old Toddler

Toys for this age group should be safe and be able to withstand a toddler's curious nature.

- Cloth or plastic books with large pictures
- Sturdy dolls
- Kiddy cars
- Musical tops
- Nesting blocks
- Push and pull toys (remember — no long strings)
- Stacking toys
- Toy telephones

Continued, over ...

Two- to Five-Year-Old Preschooler

Toys for this age group are usually experimental and should imitate the activity of parents and older children.

- Books (short stories or action stories)
- Blackboard and chalk
- Building blocks
- Crayons, nontoxic finger paints, clay
- Hammer and bench
- Housekeeping toys
- Outdoor toys: sandbox (with a lid), slide, swing, playhouse
- Transportation toys (tricycles, cars, wagons)
- Tape or record player
- Simple puzzles with large pieces
- Dress-up clothes
- Tea party utensils

Five- to Nine-Year-Old Child

Toys for this age group should help your child promote skill development and creativity.

- Blunt scissors, sewing sets
- Card games
- Doctor and nurse kits
- Hand puppets
- Balls
- Bicycles
- Crafts
- Electric trains
- Paper dolls
- Jump ropes
- Roller skates
- Sports equipment
- Table games

Ten- to Fourteen-Year-Old Child

Hobbies and scientific activities are ideal for this age group.

- Nonviolent or educational computer games
- Sewing, knitting, needlework
- Microscopes/telescopes
- Table and board games
- Sports equipment
- Hobby collections

Toy Tips for the Holidays courtesy of the American Academy of Pediatrics

The Brown University Child and Adolescent Behavior Letter

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rious consequences than roller skating or in-line skating injuries," the researchers conclude. "Research is needed to identify ergonomic and behavioral factors responsible for higher head injury risk to skateboarders, and interventions are needed to reduce the risk."

Osberg JS, Schneps SE, Scala CD, et al.: Skateboarding: More dangerous than roller skating or in-line skating. *Archives of Pediatric and Adolescent Medicine* 1998; 152:985-991. For reprints, contact J. Scott Osberg, Ph.D., New England Medical Center, 75 Kneeland St., Fifth Floor, Rehabilitation, Boston, MA 02111.

TV, music videos linked to adolescent alcohol use

Attempts to prevent adolescent alcohol use should address the adverse influences of alcohol use in the media, say researchers who recently conducted a prospective cohort study of 1,533 ninth-grade students in six public high schools in San Jose, Calif. The researchers evaluated students' hours of television, music video and videotape viewing as well as their use of computers and video games. The students also were asked about their alcohol use at baseline and 18 months later.

During the 18-month follow-up, 36.2 percent of students who had been nondrinkers at baseline began drinking and 50.7 percent of students who had been drinkers at baseline continued to drink. In addition, the onset of drinking was significantly associated with baseline hours of television viewing, music video viewing and videotape viewing. Computer and video game use was not significantly associated with the onset of drinking.

"Increased television and music video viewing are risk factors for the onset of alcohol use in adolescents," the authors conclude.

Robinson TN, Chen HL, Killen JD.: Television and music video exposure and risk of adolescent alcohol use. *Pediatrics* 1998; 102:54-66. For reprints, contact Thomas N. Robinson, M.D., Department of Pediatrics, Stanford Center for Research in Disease Prevention, Stanford University School of Medicine, 1000 Welch Road, Palo Alto, CA 94304.

Gratitude
from page 1

with the building blocks of "please" and "thank you," and regularly reminds Jon and his four siblings not to take things for granted.

"If someone gives my kids something, I always encourage them to say thank you, and to realize that people are giving to them not because they *have to* but because they *want to*, out of the goodness of their heart," says Morgan. "We tell the kids thanks for little things, too. It's an ongoing thing with us."

Experts say Morgan is doing the right thing. They recommend parents "model" appreciation and other desirable behaviors they want youngsters to absorb.

"Ultimately, children are likely to learn to show gratitude naturally if they observe similar behavior played out within the family," said the late Julius Segal, a psychologist and author who wrote a regular column for Parents magazine.

This begins with simple gestures such as expressing appreciation to one another for everyday kindnesses — such as finding a misplaced slipper or feeding the dog without being asked — as well as for more tangible things like gifts, he says. If kids see parents writing thank-you notes, they're more likely to get into the habit, too. (Thank-you phone calls, however, also are acceptable.)

Sharon Gioia, a West Bloomfield, Mich., etiquette consultant who teaches manners workshops at Dearborn's Ritz-Carlton and elsewhere in Metro Detroit, says parents can reinforce gratitude in their children by discussing gifts and kind gestures with them.

"Explain how wonderful it is that Grandma took the time to get you this toy you really wanted. It teaches the child a process — that you just don't say, 'I want this, I want this,' and it appears," she says.

Rituals, such as blessings before meals and bedtime, are other ways to instill feelings of appreciation.

"I've even seen families where everyone around the table tells what they feel grateful for in the week just past," Segal noted. "It sounds like it's out of a 1940s movie, but there's nothing wrong with that."

All children, Segal and other behavioral psychologists say, are born with the instinct of gratitude, though some express it better than others as they mature. It isn't until sometime between the ages of four and six, however, that youngsters can begin to comprehend that others have a choice in how they behave toward them, says Harvard University developmental psychologist Jerome Kagan.

"That's when the child can truly take the perspective of others and recognize that the dinner parents make, for example, requires effort for the family," he says.

Lewis Lipsitt, editor, professor

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emeritus of psychology, medical science and human development at Brown University, says some children don't learn gratitude easily — or they lose the natural inclination toward it — because they receive rewards regardless of how they behave.

"They're getting the goodies of the world noncontingently, without doing anything to get them," he says. "They're rewarded so frequently, and it's not dependent on their own behavior, that they lose that gesture of gratitude. As a consequence, they grow up looking like thankless people."

No matter how diligent a parent is on instilling gratitude in a child, there will be times when children don't seem to appreciate a gift or good deed.

When this happens, especially in the presence of the giver, Segal said, children should be taken aside and reminded to show thanks, rather than chastised publicly.

"Point out how that makes the giver feel. Children learn empathy by being told, 'I feel let down or Dad feels let down — we went to a lot of trouble to choose that gift or pay for that gift,'" he says.

"Tell the child, 'You may feel that in your heart, but it's really important for you to say thank you.'"

But Kagan cautions parents not to push too hard. "It's easy to make the child super-sensitive about his or her appreciation," he says. "Parents walk a narrow line between (fostering) mild appreciation vs. guilt over getting all these nice gifts."

At the same time, Segal advised, reinforce children when they do show gratitude. "Praise your child, comment on it. It's not just a case of correcting behavior that falls short. You have to praise and reinforce behavior that fills the bill."

And children should have meaningful opportunities to give as well as get.

"It's one thing to drop a coin in an envelope or bring clothes to some central collection point," Segal said, "but it's quite another, even when children are five or six, to visit nursing homes and help an older person with a chore or actually prepare trays for homeless people and see that they have a hot meal on a cold night." ■

Susan R. Pollack is a Detroit News staff writer. An earlier version of this article appeared in The Detroit News. It is adapted here by permission of Mark Silverman, publisher and editor.

Tips for raising a grateful child

- ✓ Teach children the importance of saying "please" and "thank you" early in their lives.
- ✓ Set an example for your child. If they hear you expressing your appreciation or watch you writing thank-you notes, they're likely to do it, too.
- ✓ Rituals, such as blessings before meals and bedtime, are other ways to instill feelings of appreciation.
- ✓ Do things for others and involve your child in the giving process, too.
- ✓ When a child receives a gift, reinforce his or her feelings of gratitude with an observation such as: "Isn't it nice that Grandma took the time to pick out this gift for you?"
- ✓ If a child fails to show appreciation for a gift or gesture, take the child aside and remind him or her why it's important to show thanks.

Suicide
from page 1

ask a question or make an observation in front of their peers. To counteract that dangerous hesitancy, I begin my presentations by telling of my experience with suicide, invite them write any questions they have about suicide on a three-by-five card and return it to me anonymously. I assure them that if I haven't answered their question in the course of my presentation, I will look at each card and answer all questions before I conclude.

Teens respond positively to both the privacy afforded in writing out questions and the assurance that, before our time together ends, their questions will be answered. This is particularly meaningful when addressing a series of classes or groups. Word spreads fast, and when you honor your commitment to answer questions in one group, the groups that follow feel confident that they, too, will be answered.

Why?

The leading question by far is

always why. Why would someone want to kill himself or herself? I answer by emphasizing the well-known risk factors such as previous attempts, substance abuse, mental health problems, issues surrounding sexual orientation and, especially, depression. Most teenagers are not aware that if they experience depression and let it go untreated, it is an inherent threat to their well being. They have little awareness of the danger untreated depression can have to their family, social and personal relationships as well as to their academic and other critical adjustments. It is important to tell them that the pain that comes with depression can be so intolerable that a person will do whatever they can to escape it.

The preventive message: *if ever you dwell upon the thought that the world would be a better place without you, you must seek help immediately.*

How can you help someone who is suicidal?

The second most frequently asked question is, "What can you do about a person you know who is suicidal and who won't let you help?"

This question inevitably is asked in writing by very concerned teens. My regard for our young people is greatly reaffirmed because they have such inherent decency and concern for one another.

This question more than any other provides an opportunity to relieve a tired and frustrated teen of an enormous burden. Once they know, as do our professionals, that when someone is experiencing serious depression that person may be unable to accept normal reaching out and, in fact, may push away a well-meaning friend, it gives them the understanding they need to make a significant difference for the person at risk.

Teens are amazingly relieved to learn that their felt rejection is a symptom of the other person's distress, and not a personal affront. After recognizing this, teens often tell me they are willing to stay the course, continue friendly dialogue and talk with a trusted adult about the situation. Knowledge does translate into action.

If ever you dwell upon the thought that the world would be a better place without you, you must seek help immediately.

How do people commit suicide?

Every reported survey shows suicide to be in the top three areas of concern expressed by teens. They spend a lot of time talking about it. Most of them know someone who died from suicide. Many have been thinking about it as an option and, regrettably, the Gallup surveys of 1991 and 1994 found that 6 percent have attempted suicide. It isn't that big a leap to understand their curiosity about the "how" of terminating life.

When this question is asked, I always discuss the lethality of guns and the fact that more than 60 percent of completed suicides result from a self-inflicted gunshot. In a household where someone has talked of suicide, or demonstrated any other signs that he or she might be thinking of taking his or her life, access to such deadly weapons must be totally restricted.

There are always other questions, of course, but these three continue to be the most often asked. Anytime a question is asked about suicide, we are given a unique opportunity to bring light, and ultimately power, to our young people, who can convert the knowledge and energy into self-protection. ■

W. Brian Barr is a certified social worker and a credentialed alcoholism and drug abuse counselor. He is associate commissioner of the State of New York Office of Children and Family Services.

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Commentary

The humane technology of parenting

I frequently hear from parents that they never knew how difficult the challenges of parenthood were going to be. Raising children has become, over the past 100 years, one of the toughest enterprises for humans in developed societies.

This is not a fuddy-duddy's regret over times past, or a new refrain on the old lament that "things just aren't what they used to be." Parenting has always been a responsibility, and sometimes terrifying, for conscientious mothers and fathers. But conditions exist today such as never existed before, and the positively accelerated changes that occurred over the past hundred years have presented a situation entirely unlike any in the history of parenthood. Technological changes have loomed large during this period. And new parents have come to believe that the physical conveniences they have had during their childhood and adolescence await them as they now become moms and dads.

The technology of parenting is in the smile, the face to face posture, the reciprocating vocalizations, the look in the eye, the touch, the smell and the great sense of being cared for. No special equipment is required.

I don't think that mothers and fathers in pre-industrial America felt as conflicted, or were so worried and frustrated with themselves over the inability to perform properly as parents. Self-help-for-parents books and magazines are selling fast. Parenting and child-rearing specialists are among the most sought-after speakers. There is a sense of lack of personal expertise out there.

My perception is that today's parents went into production with their families assuming that the technology for parenting is here for them. After all, the media show babies sucking from new types of nipples (call them "prosthetic"!), the bottles are shaped to permit better fluid flow, diapers are handy-dandy and throwaway, carriages come with gears and soft, bouncy tires, toys are touted as little miracle-workers for the baby's brain, and a mini-TV camera in the baby's room will let you watch and hear your baby at any time of the day or night.

The age of technology has led young people to think that parenting technology is also at their service.

Why shouldn't young parents believe we are living in an age of *technocratic child-rearing*? They have grown up with conveniences just recently conceived and created. Virtually unimagined over a hundred years ago, we have ready access to cars, trains, indoor toilets, planes, telephones, TV, computers, sonographic sighting of the baby before birth, vaccines, condoms, beepers and 911.

A particularly sensitive teacher recently shared with me an observation — that when parents drive their kids to school and to other activities, the kids and parents are usually looking out the windows, not talking to and looking at each other; when watching TV, they are not interacting; and they frequently eat meals alone.

What young people and new parents don't realize is that the fine-tuned technology of parenting has little to do with modern implements, communications conveniences or stylish vehicles. These appurtenances are extra added attractions. They facilitate. They service. They don't make a parent.

The technology of parenting is in the smile, the face to face posture, the reciprocating vocalizations, the look in the eye, the touch, the smell and the great sense of being cared for. No special equipment is required.

If there is a major lesson to be learned from the latest findings from the *science* of child development — the same kind of science that has given us cars and computers and space travel — good parenting has little to do with machinery and has everything to do with raw, bare, unencumbered, unscheduled, imprecise, spontaneous, caring and trusting parent-child relationships.

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